

106TH CONGRESS
1ST SESSION

S. 24

To provide improved access to health care, enhance informed individual choice regarding health care services, lower health care costs through the use of appropriate providers, improve the quality of health care, improve access to long-term care, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JANUARY 19, 1999

Mr. SPECTER introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To provide improved access to health care, enhance informed individual choice regarding health care services, lower health care costs through the use of appropriate providers, improve the quality of health care, improve access to long-term care, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Health Care Assurance Act of 1999”.

6 (b) TABLE OF CONTENTS.—The table of contents for
7 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—EXPANSION OF THE STATE CHILDREN’S HEALTH
INSURANCE PROGRAM

Sec. 101. Increase in income eligibility.

TITLE II—EXPANDED HEALTH SERVICES FOR DISABLED
INDIVIDUALS

Sec. 201. Extension of medicare eligibility for disabled individuals who return
to work.

Sec. 202. Coverage of community-based attendant services under the medicaid
program.

Sec. 203. State option for medicaid eligibility for certain individuals.

TITLE III—HEALTH CARE INSURANCE COVERAGE

Subtitle A—General Provisions

Sec. 301. Amendments to the Employee Retirement Income Security Act of
1974.

“SUBPART C—GENERAL INSURANCE COVERAGE REFORMS

“CHAPTER 1—INCREASED AVAILABILITY AND CONTINUITY OF
HEALTH COVERAGE

“Sec. 721. Definition.

“Sec. 721A. Actuarial equivalence in benefits permitted.

“Sec. 721B. Establishment of plan standards.

“Sec. 721C. Rating limitations for community-rated market.

“Sec. 721D. Rating practices and payment of premiums.

“Sec. 721E. Qualified small employer purchasing groups.

“Sec. 721F. Agreements with small employers.

“Sec. 721G. Enrolling eligible employees, eligible individuals, and certain
uninsured individuals in qualified group health plans.

“Sec. 721H. Receipt of premiums.

“Sec. 721I. Marketing activities.

“Sec. 721J. Grants to States and qualified small employer purchasing
groups.

“Sec. 721K. Qualified small employer purchasing groups established by a
State.

“Sec. 721L. Effective dates.

“CHAPTER 2—REQUIRED COVERAGE OPTIONS FOR ELIGIBLE
EMPLOYEES AND DEPENDENTS OF SMALL EMPLOYERS

“Sec. 722. Requiring small employers to offer coverage for eligible individ-
uals.

“Sec. 722A. Compliance with applicable requirements through multiple
employer health arrangements.

“CHAPTER 3—REQUIRED COVERAGE OPTIONS FOR INDIVIDUALS
INSURED THROUGH ASSOCIATION PLANS

“SUBCHAPTER A—QUALIFIED ASSOCIATION PLANS

“Sec. 723. Treatment of qualified association plans.

“Sec. 723A. Qualified association plan defined.

“Sec. 723B. Definitions and special rules.

“SUBCHAPTER B—SPECIAL RULE FOR CHURCH, MULTIEMPLOYER, AND
COOPERATIVE PLANS

“Sec. 723F. Special rule for church, multiemployer, and cooperative plans.

Sec. 302. Amendments to the Public Health Service Act relating to the group
market.

“CHAPTER 2—GENERAL INSURANCE COVERAGE REFORMS

“SUBCHAPTER A—INCREASED AVAILABILITY AND CONTINUITY OF HEALTH
COVERAGE

“Sec. 2707. Definition.

“Sec. 2707A. Actuarial equivalence in benefits permitted.

“Sec. 2707B. Establishment of plan standards.

“Sec. 2707C. Rating limitations for community-rated market.

“Sec. 2707D. Rating practices and payment of premiums.

“Sec. 2707E. Qualified small employer purchasing groups.

“Sec. 2707F. Agreements with small employers.

“Sec. 2707G. Enrolling eligible employees, eligible individuals, and certain
uninsured individuals in qualified group health plans.

“Sec. 2707H. Receipt of premiums.

“Sec. 2707I. Marketing activities.

“Sec. 2707J. Grants to States and qualified small employer purchasing
groups.

“Sec. 2707K. Qualified small employer purchasing groups established by a
State.

“Sec. 2707L. Effective dates.

“SUBCHAPTER B—REQUIRED COVERAGE OPTIONS FOR ELIGIBLE EMPLOYEES
AND DEPENDENTS OF SMALL EMPLOYERS

“Sec. 2708. Requiring small employers to offer coverage for eligible indi-
viduals.

“Sec. 2708A. Compliance with applicable requirements through multiple
employer health arrangements.

“SUBCHAPTER C—REQUIRED COVERAGE OPTIONS FOR INDIVIDUALS INSURED
THROUGH ASSOCIATION PLANS

“Sec. 2709. Treatment of qualified association plans.

“Sec. 2709A. Qualified association plan defined.

“Sec. 2709B. Definitions and special rules.

“Sec. 2709C. Special rule for church, multiemployer, and cooperative
plans.

Sec. 303. Amendment to the Public Health Service Act relating to the individ-
ual market.

“Sec. 2753. Applicability of general insurance market reforms.

Sec. 304. Effective date.

Subtitle B—Tax Provisions

Sec. 311. Enforcement with respect to health insurance issuers.

“Sec. 4980F. Failure of insurer to comply with certain standards for health insurance coverage.

- Sec. 312. Enforcement with respect to small employers.
- Sec. 313. Enforcement by excise tax on qualified associations.
- Sec. 314. Deduction for health insurance costs of self-employed individuals.
- Sec. 315. Amendments to COBRA.

TITLE IV—PRIMARY AND PREVENTIVE CARE SERVICES

- Sec. 401. Improvement of medicare preventive care services.
- Sec. 402. Authorization of appropriations for healthy start program.
- Sec. 403. Reauthorization of certain programs providing primary and preventive care.
- Sec. 404. Comprehensive school health education program.
- Sec. 405. Comprehensive early childhood health education program.
- Sec. 406. Adolescent family life and abstinence.

TITLE V—PATIENT’S RIGHT TO DECLINE MEDICAL TREATMENT

- Sec. 501. Patient’s right to decline medical treatment.

TITLE VI—PRIMARY AND PREVENTIVE CARE PROVIDERS

- Sec. 601. Increased medicare reimbursement for physician assistants, nurse practitioners, and clinical nurse specialists.
- Sec. 602. Requiring coverage of certain nonphysician providers under the medicaid program.
- Sec. 603. Medical student tutorial program grants.
- Sec. 604. General medical practice grants.

TITLE VII—COST CONTAINMENT

- Sec. 701. New drug clinical trials program.
- Sec. 702. Medical treatment effectiveness.
- Sec. 703. Health care cost containment and quality information program.

TITLE VIII—TAX INCENTIVES FOR PURCHASE OF QUALIFIED LONG-TERM CARE INSURANCE

- Sec. 801. Credit for qualified long-term care premiums.
- Sec. 802. Inclusion of qualified long-term care insurance in cafeteria plans and flexible spending arrangements.
- Sec. 803. Exclusion from gross income for amounts received on cancellation of life insurance policies and used for qualified long-term care insurance contracts.
- Sec. 804. Use of gain from sale of principal residence for purchase of qualified long-term health care insurance.

TITLE IX—NATIONAL FUND FOR HEALTH RESEARCH

- Sec. 901. Establishment of Fund.

1 **TITLE I—EXPANSION OF THE**
 2 **STATE CHILDREN’S HEALTH**
 3 **INSURANCE PROGRAM**

4 **SEC. 101. INCREASE IN INCOME ELIGIBILITY.**

5 (a) DEFINITION OF LOW-INCOME CHILD.—Section
 6 2110(c)(4) of the Social Security Act (42 U.S.C. 42
 7 U.S.C. 1397jj(c)(4)) is amended by striking “200” and
 8 inserting “235”.

9 (b) EFFECTIVE DATE.—The amendment made by
 10 subsection (a) takes effect on October 1, 1999.

11 **TITLE II—EXPANDED HEALTH**
 12 **SERVICES FOR DISABLED IN-**
 13 **DIVIDUALS**

14 **SEC. 201. EXTENSION OF MEDICARE ELIGIBILITY FOR DIS-**
 15 **ABLED INDIVIDUALS WHO RETURN TO WORK.**

16 (a) ADDITIONAL 24 MONTHS OF MEDICARE COV-
 17 ERAGE FOR OASDI DISABILITY BENEFIT RECIPIENTS
 18 WHO ARE WORKING.—The next to last sentence of section
 19 226(b) of the Social Security Act (42 U.S.C. 426(b)) is
 20 amended—

21 (1) by striking “throughout all of which” and
 22 inserting “throughout the first 24 months of which”;
 23 and

24 (2) by inserting after “but not in excess of 24
 25 such months” the following: “(plus 24 additional

1 such months in the case of an individual who the
 2 Commissioner determines would otherwise be enti-
 3 tled to hospital insurance benefits under part A of
 4 title XVIII but for the individual having earnings
 5 that exceed the substantial gainful activity amount
 6 (as defined in section 223(d)(4)))”.

7 (b) MEDICARE BUY-IN FOR OASDI DISABILITY
 8 BENEFIT RECIPIENTS WHO ARE WORKING.—

9 (1) IN GENERAL.—Section 1818A(d) of the So-
 10 cial Security Act (42 U.S.C. 1395i–2a(d)) is amend-
 11 ed by adding at the end the following:

12 “(3)(A) In the case of an individual described in sub-
 13 paragraph (B), the monthly premium for a month shall
 14 be paid for in the following manner:

15 “(i) If the individual’s income does not exceed
 16 150 percent of the income official poverty line (as
 17 defined by the Office of Management and Budget,
 18 and revised annually in accordance with section
 19 673(2) of the Omnibus Budget Reconciliation Act of
 20 1981), 100 percent by the State of the individual’s
 21 residence under the medicaid program under title
 22 XIX.

23 “(ii) If the individual’s income exceeds 150 but
 24 does not exceed 185 percent of the income official
 25 poverty line (as so defined), 75 percent by such

1 State under the medicaid program under title XIX
2 and 25 percent by the individual.

3 “(iii) If the individual’s income exceeds 185 but
4 does not exceed 200 percent of the income official
5 poverty line (as so defined), 50 percent by such
6 State under the medicaid program under title XIX
7 and 50 percent by the individual.

8 “(B) An individual is described in this subparagraph
9 if—

10 “(i) the individual establishes to the satisfaction
11 of the Secretary, subject to an annual review, that
12 the individual continues to satisfy the enrollment re-
13 quirements of subsection (a);

14 “(ii) the individual is not eligible for assistance
15 with payment of premiums for enrollment in the in-
16 surance program established by this part or with
17 payment of other cost-sharing imposed under this
18 part under title XIX, other than under section
19 1902(a)(10)(E)(v), or under any other Federal or
20 State assistance program; and

21 “(iii) the individual’s income does not exceed
22 200 percent of the income official poverty line (as so
23 defined).

24 “(C) Nothing in this paragraph shall be construed as
25 exempting an individual described in subparagraph (B)

1 from being subject to any requirements relating to cost-
 2 sharing that are imposed under the insurance program es-
 3 tablished under this part.”.

4 (2) MEDICAID PAYMENT FOR COVERAGE.—Sec-
 5 tion 1902(a)(10)(E) of the Social Security Act (42
 6 U.S.C. 1396a(a)(10)(E)) is amended—

7 (A) in clause (iii), by striking “and” at the
 8 end; and

9 (B) by adding at the end the following:

10 “(v) for making medical assistance avail-
 11 able for payment of medicare cost-sharing de-
 12 scribed in section 1905(p)(3)(A)(i) in accord-
 13 ance with section 1818A(d)(3)(A) for individ-
 14 uals described in section 1818A(d)(3)(B); and”

15 (3) EFFECTIVE DATE.—The amendments made
 16 by this section take effect October 1, 1999.

17 **SEC. 202. COVERAGE OF COMMUNITY-BASED ATTENDANT**
 18 **SERVICES UNDER THE MEDICAID PROGRAM.**

19 (a) REQUIRING COVERAGE FOR INDIVIDUALS ENTI-
 20 TLED TO NURSING FACILITY SERVICES OR INTERMEDI-
 21 ATE CARE FACILITY SERVICES FOR THE MENTALLY RE-
 22 TARDED.—Section 1902(a)(10)(D) of the Social Security
 23 Act (42 U.S.C. 1396a(a)(10)(D)) is amended—

24 (1) by inserting “(i)” after “(D)”, and

25 (2) by adding at the end the following:

“(ii) subject to section 1935(b), for the inclusion of qualified community-based attendant services for any individual who, under the State plan, is entitled to nursing facility services or intermediate care facility services for the mentally retarded and who requires such services based on functional need (and without regard to age or disability);”.

(b) MEDICAID COVERAGE OF COMMUNITY-BASED ATTENDANT SERVICES.—

(1) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended—

(A) by redesignating section 1935 as section 1936, and

(B) by inserting after section 1934 the following new section:

“COVERAGE OF QUALIFIED COMMUNITY-BASED ATTENDANT SERVICES

“SEC. 1935. (a) QUALIFIED COMMUNITY-BASED ATTENDANT SERVICES DEFINED.—

“(1) IN GENERAL.—In this title, the term ‘qualified community-based attendant services’ means attendant services (as defined by the Secretary) furnished to an individual—

“(A) on an as-needed basis under a plan of service that is based on an assessment of func-

1 tional need and that is agreed to by the individ-
2 ual;

3 “(B) in a home or community-based set-
4 ting, which may include a school, workplace, or
5 recreation or religious facility, but does not in-
6 clude a nursing facility, an intermediate care
7 facility for the mentally retarded, or other insti-
8 tutional facility;

9 “(C) under either an agency-provider
10 model or other model (as defined in subsection
11 (c)); and

12 “(D) the furnishing of which is selected,
13 managed, controlled by the individual (as de-
14 fined by the Secretary).

15 “(2) SERVICES INCLUDED.—Such term
16 includes—

17 “(A) backup and emergency attendant
18 services;

19 “(B) voluntary training on how to select,
20 manage, and dismiss attendants; and

21 “(C) health-related tasks (as defined by
22 the Secretary) that are assigned to, delegated
23 to, or performed by, unlicensed personal attend-
24 ants.

1 “(3) EXCLUDED SERVICES.—Subject to para-
2 graph (4), such term does not include—

3 “(A) provision of room and board, and

4 “(B) prevocational, vocational, and sup-
5 ported employment.

6 “(4) FLEXIBILITY IN TRANSITION TO HOME
7 SETTING.—Under regulations of the Secretary, such
8 term may include expenditures for transitional costs,
9 such as rent and utility deposits, first months’s rent
10 and utilities, bedding, basic kitchen supplies, and
11 other necessities required for an individual to make
12 the transition from a nursing facility or intermediate
13 care facility for the mentally retarded to a home set-
14 ting.

15 “(b) LIMITATION ON AMOUNTS OF EXPENDITURES
16 AS MEDICAL ASSISTANCE.—

17 “(1) IN GENERAL.—In carrying out section
18 1902(a)(10)(D)(ii), a State shall permit an individ-
19 ual who is entitled to medical assistance with respect
20 to nursing facility services or intermediate care facil-
21 ity services for the mentally retarded and who quali-
22 fies for the receipt of such services to choose to re-
23 ceive medical assistance for qualified community-
24 based attendant services (rather than medical assist-
25 ance for such institutional services), in the most in-

1 tegrated setting appropriate to the needs of the indi-
 2 vidual, so long as the aggregate amount of the Fed-
 3 eral expenditures for such individuals in a fiscal year
 4 does not exceed the total that would have been ex-
 5 pended for such individuals to receive such institu-
 6 tional services in the year plus, subject to subsection
 7 (e), the transitional allotment to the State for the
 8 fiscal year involved, as determined under paragraph
 9 (2)(B).

10 “(2) TRANSITIONAL ALLOTMENTS.—

11 “(A) TOTAL AMOUNT.—The total amount
 12 of the transitional allotments under this para-
 13 graph for—

14 “(i) fiscal year 2000 is \$580,000,000,

15 “(ii) fiscal year 2001 is \$480,000,000,

16 “(iii) fiscal year 2002 is
 17 \$380,000,000,

18 “(iv) fiscal year 2003 is
 19 \$280,000,000,

20 “(v) fiscal year 2004 is \$180,000,000

21 and

22 “(vi) fiscal year 2005 is
 23 \$100,000,000.

24 “(B) STATE ALLOTMENTS.—The Secretary
 25 shall provide a formula for the distribution of

the total amount of the transitional allotments provided in each fiscal year under subparagraph (A) among States. Such formula shall give preference to States that have a relatively higher proportion of long-term care services furnished to individuals in an institutional setting but who have a plan under subsection (e) to significantly reduce such proportion.

“(C) USE OF FUNDS.—Such funds allotted to, but not expended in, a fiscal year to a State are available for expenditure in the succeeding fiscal year.

“(c) DELIVERY MODELS.—For purposes of this section:

“(1) AGENCY-PROVIDER MODEL.—The term ‘agency-provider model’ means, with respect to the provision of community-based attendant services for an individual, a method of providing such services under which a single entity contracts for the provision of such services.

“(2) OTHER MODEL.—The term ‘other model’ means a method, other than an agency-provider model, for provision of services. Such a model may include the provision of vouchers, direct cash pay-

1 ments, or use of a fiscal agent to assist in obtaining
2 services.

3 “(d) QUALITY ASSURANCE.—

4 “(1) IN GENERAL.—No Federal financial par-
5 ticipation shall be available with respect to qualified
6 community-based attendant services furnished under
7 an agency-provider model or other model unless the
8 State establishes and maintains a quality assurance
9 program that is developed after public hearings, that
10 is based on consumer satisfaction, and that, in the
11 case of services furnished under the agency-provider
12 model, meets the following requirements:

13 “(A) SURVEY AND CERTIFICATION.—The
14 State periodically certifies and surveys such
15 provider-agencies. Such surveys are conducted
16 on an unannounced basis and average at least
17 1 a year for each agency-provider.

18 “(B) STANDARDS.—The State adopts
19 standards for survey and certification that
20 include—

21 “(i) minimum qualifications and train-
22 ing requirements for provider staff;

23 “(ii) financial operating standards;
24 and

25 “(iii) a consumer grievance process.

1 “(C) MONITORING BOARDS.—The State
2 provides a system that allows for monitoring
3 boards consisting of providers, family members,
4 consumers, and neighbors to advise and assist
5 the State.

6 “(D) PUBLIC REPORTING.—The State es-
7 tablishes reporting procedures to make available
8 information to the public.

9 “(E) ONGOING MONITORING.—The State
10 provides ongoing monitoring of the delivery of
11 attendant services and the effect of those serv-
12 ices on the health and well-being of each recipi-
13 ent.

14 “(2) PROTECTION OF BENEFICIARIES.—

15 “(A) IN GENERAL.—The regulations pro-
16 mulgated under section 1930(h)(1) shall apply
17 with respect to the protection of the health,
18 safety, and welfare of individuals receiving
19 qualified community-based attendant services in
20 the same manner as they apply to individuals
21 receiving community supported living arrange-
22 ments services.

23 “(B) DEVELOPMENT OF ADDITIONAL REG-
24 ULATIONS.—The Secretary shall develop addi-
25 tional regulations to protect the health, safety,

1 and welfare for individuals receiving qualified
 2 community-based attendant services other than
 3 under an agency-provider model. Such regula-
 4 tions shall be designed to maximize the consum-
 5 ers' independence and control.

6 “(C) SANCTIONS.—The provisions of sec-
 7 tion 1930(h)(2) shall apply to violations of reg-
 8 ulations described in subparagraph (A) or (B)
 9 in the same manner as they apply to violations
 10 of regulations described in section 1930(h)(1).

11 “(e) TRANSITION PLAN.—

12 “(1) IN GENERAL.—As a condition for receipt
 13 of a transitional allotment under subsection (b)(2),
 14 a State shall develop a long-term care services tran-
 15 sition plan that establishes specific action steps and
 16 specific timetables to increase the proportion of long-
 17 term care services provided under the plan under
 18 this title in home and community-based settings,
 19 rather than institutional settings.

20 “(2) PARTICIPATION.—The plan under para-
 21 graph (1) shall be developed with major participa-
 22 tion by both the State Independent Living Council
 23 and the State Developmental Disabilities Council, as
 24 well as input from the Councils on Aging.

1 “(f) ELIGIBILITY.—Effective January 1, 2001, a
 2 State may not exercise the option of coverage of individ-
 3 uals under section 1902(a)(10)(A)(ii)(V) without provid-
 4 ing coverage under section 1902(a)(10)(A)(ii)(VI).

5 “(g) REPORT ON IMPACT OF SECTION.—The Sec-
 6 retary shall submit to Congress periodic reports on the
 7 impact of this section on beneficiaries, States, and the
 8 Federal Government.”.

9 (c) COVERAGE AS MEDICAL ASSISTANCE.—

10 (1) IN GENERAL.—Section 1905(a) of the So-
 11 cial Security Act (42 U.S.C. 1396d) is amended—

12 (A) by striking “and” at the end of para-
 13 graph (26),

14 (B) by redesignating paragraph (27) as
 15 paragraph (28), and

16 (C) by inserting after paragraph (26) the
 17 following new paragraph:

18 “(27) qualified community-based attendant
 19 services (to the extent allowed and as defined in sec-
 20 tion 1935); and”.

21 (2) ELIGIBILITY CLASSIFICATIONS.—Section
 22 1902(a)(10)(A)(ii)(VI) of the Social Security Act
 23 (42 U.S.C. 1396a(a)(10)(A)(ii)(VI)) is amended by
 24 inserting “or qualified community-based attendant

1 services” after “section 1915” each time such term
 2 appears.

3 (3) CONFORMING AMENDMENTS.—

4 (A) Section 1902(j) of the Social Security
 5 Act (42 U.S.C. 1396a(j)) is amended by strik-
 6 ing “of of” and inserting “of”.

7 (B) Section 1902(a)(10)(C)(iv) of the So-
 8 cial Security Act (42 U.S.C.
 9 1396a(a)(10)(C)(iv)) is amended by inserting
 10 “and (27)” after “(24)”.

11 (d) REVIEW OF, AND REPORT ON, REGULATIONS.—
 12 The Secretary of Health and Human Services shall review
 13 existing regulations under title XIX of the Social Security
 14 Act (42 U.S.C. 1396 et seq.) insofar as they regulate the
 15 provision of home health services and other services in
 16 home and community-based settings. The Secretary shall
 17 submit to Congress a report on how excessive utilization
 18 of medical services can be reduced under such title by
 19 using qualified community-based attendant services.

20 (e) DEVELOPMENT OF FUNCTIONAL NEEDS ASSESS-
 21 MENT INSTRUMENT.—The Secretary of Health and
 22 Human Services shall develop a functional needs assess-
 23 ment instrument that assesses an individual’s need for
 24 qualified community-based attendant services and that

1 may be used in carrying out sections 1902(a)(10)(D)(ii)
 2 and 1935 of the Social Security Act.

3 (f) TASK FORCE ON FINANCING OF LONG-TERM
 4 CARE SERVICES.—The Secretary of Health and Human
 5 Services shall establish a task force to examine appro-
 6 priate methods for financing long-term care services. Such
 7 task force shall include significant representation of indi-
 8 viduals (and representatives of individuals) who receive
 9 such services.

10 (g) EFFECTIVE DATE.—The amendments made by
 11 subsections (a), (b), and (c) shall apply to medical assist-
 12 ance provided for items and services furnished on or after
 13 January 1, 2000.

14 **SEC. 203. STATE OPTION FOR MEDICAID ELIGIBILITY FOR**
 15 **CERTAIN INDIVIDUALS.**

16 (a) IN GENERAL.—Section 1903(f) of the Social Se-
 17 curity Act (42 U.S.C. 1396b(f)) is amended—

18 (1) in paragraph (4)(C), by inserting “subject
 19 to paragraph (5),” after “does not exceed”, and

20 (2) by adding at the end the following:

21 “(5)(A) A State may waive the income limitation de-
 22 scribed in paragraph (4)(C) in such cases as the State
 23 finds the potential for employment opportunities would be
 24 enhanced through the provision of such services.

1 “(B) In the case of an individual who is made eligible
 2 for medical assistance because of subparagraph (A), not-
 3 withstanding section 1916(b), the State may impose a pre-
 4 mium based on a sliding scale relating to income.”.

5 (b) EFFECTIVE DATE.—The amendments made by
 6 subsection (a) shall apply to medical assistance provided
 7 for items and services furnished on or after January 1,
 8 2000.

9 **TITLE III—HEALTH CARE**
 10 **INSURANCE COVERAGE**
 11 **Subtitle A—General Provisions**

12 **SEC. 301. AMENDMENTS TO THE EMPLOYEE RETIREMENT**
 13 **INCOME SECURITY ACT OF 1974.**

14 (a) IN GENERAL.—Part 7 of subtitle B of title I of
 15 the Employee Retirement Income Security Act of 1974
 16 (29 U.S.C. 1181 et seq.) is amended—

17 (1) by redesignating subpart C as subpart D;

18 and

19 (2) by inserting after subpart B, the following:

3 **“CHAPTER 1—INCREASED AVAILABILITY AND**
4 **CONTINUITY OF HEALTH COVERAGE**

6 “As used in this subpart, the term ‘qualified group
7 health plan’ means a group health plan, and a health in-
8 surance issuer offering group health insurance coverage,
9 that is designed to provide standard coverage (consistent
10 with section 721A(b)).

11 "SEC. 721A. ACTUARIAL EQUIVALENCE IN BENEFITS PER-
12 MITTED.

“(1) INITIAL DETERMINATION.—The NAIC is requested to submit to the Secretary, within 6 months after the date of the enactment of this subpart, a set of rules which the NAIC determines is sufficient for determining, in the case of any group health plan, or a health insurance issuer offering group health insurance coverage, and for purposes of this section, the actuarial value of the coverage offered by the plan or coverage.

23 “(2) CERTIFICATION.—If the Secretary deter-
24 mines that the NAIC has submitted a set of rules
25 that comply with the requirements of paragraph (1),

1 the Secretary shall certify such set of rules for use
 2 under this subpart. If the Secretary determines that
 3 such a set of rules has not been submitted or does
 4 not comply with such requirements, the Secretary
 5 shall promptly establish a set of rules that meets
 6 such requirements.

7 “(b) STANDARD COVERAGE.—

8 “(1) IN GENERAL.—A group health plan, and a
 9 health insurance issuer offering group health insur-
 10 ance coverage, shall be considered to provide stand-
 11 ard coverage consistent with this subsection if the
 12 benefits are determined, in accordance with the set
 13 of actuarial equivalence rules certified under sub-
 14 section (a), to have a value that is within 5 percent-
 15 age points of the target actuarial value for standard
 16 coverage established under paragraph (2).

17 “(2) INITIAL DETERMINATION OF TARGET AC-
 18 TUARIAL VALUE FOR STANDARD COVERAGE.—

19 “(A) INITIAL DETERMINATION.—

20 “(i) IN GENERAL.—The NAIC is re-
 21 quested to submit to the Secretary, within
 22 6 months after the date of the enactment
 23 of this subpart, a target actuarial value for
 24 standard coverage equal to the average ac-
 25 tuarial value of the coverage described in

1 clause (ii). No specific procedure or treat-
 2 ment, or classes thereof, is required to be
 3 considered in such determination by this
 4 subpart or through regulations. The deter-
 5 mination of such value shall be based on a
 6 representative distribution of the popu-
 7 lation of eligible employees offered such
 8 coverage and a single set of standardized
 9 utilization and cost factors.

10 “(ii) COVERAGE DESCRIBED.—The
 11 coverage described in this clause is cov-
 12 erage for medically necessary and appro-
 13 priate services consisting of medical and
 14 surgical services, medical equipment, pre-
 15 ventive services, and emergency transpor-
 16 tation in frontier areas. No specific proce-
 17 dure or treatment, or classes thereof, is re-
 18 quired to be covered in such a plan, by this
 19 subpart or through regulations.

20 “(B) CERTIFICATION.—If the Secretary
 21 determines that the NAIC has submitted a tar-
 22 get actuarial value for standard coverage that
 23 complies with the requirements of subparagraph
 24 (A), the Secretary shall certify such value for
 25 use under this chapter. If the Secretary deter-

1 mines that a target actuarial value has not been
 2 submitted or does not comply with the require-
 3 ments of subparagraph (A), the Secretary shall
 4 promptly determine a target actuarial value
 5 that meets such requirements.

6 “(c) SUBSEQUENT REVISIONS.—

7 “(1) NAIC.—The NAIC may submit from time
 8 to time to the Secretary revisions of the set of rules
 9 of actuarial equivalence and target actuarial values
 10 previously established or determined under this sec-
 11 tion if the NAIC determines that revisions are nec-
 12 essary to take into account changes in the relevant
 13 types of health benefits provisions or in demographic
 14 conditions which form the basis for the set of rules
 15 of actuarial equivalence or the target actuarial val-
 16 ues. The provisions of subsection (a)(2) shall apply
 17 to such a revision in the same manner as they apply
 18 to the initial determination of the set of rules.

19 “(2) SECRETARY.—The Secretary may by regu-
 20 lation revise the set of rules of actuarial equivalence
 21 and target actuarial values from time to time if the
 22 Secretary determines such revisions are necessary to
 23 take into account changes described in paragraph
 24 (1).

1 **“SEC. 721B. ESTABLISHMENT OF PLAN STANDARDS.**

2 “(a) ESTABLISHMENT OF GENERAL STANDARDS.—

3 “(1) ROLE OF NAIC.—The NAIC is requested
4 to submit to the Secretary, within 9 months after
5 the date of the enactment of this subpart, model
6 regulations that specify standards for making quali-
7 fied group health plans available to small employers.
8 If the NAIC develops recommended regulations
9 specifying such standards within such period, the
10 Secretary shall review the standards. Such review
11 shall be completed within 60 days after the date the
12 regulations are developed. Such standards shall
13 serve as the standards under this section, with such
14 amendments as the Secretary deems necessary. Such
15 standards shall be nonbinding (except as provided in
16 chapter 4).

17 “(2) CONTINGENCY.—If the NAIC does not de-
18 velop such model regulations within the period de-
19 scribed in paragraph (1), the Secretary shall specify,
20 within 15 months after the date of the enactment of
21 this subpart, model regulations that specify stand-
22 ards for insurers with regard to making qualified
23 group health plans available to small employers.
24 Such standards shall be nonbinding (except as pro-
25 vided in chapter 4).

1 “(3) EFFECTIVE DATE.—The standards speci-
 2 fied in the model regulations shall apply to group
 3 health plans and health insurance issuers offering
 4 group health insurance coverage in a State on or
 5 after the respective date the standards are imple-
 6 mented in the State.

7 “(b) NO PREEMPTION OF STATE LAW.—A State may
 8 implement standards for group health plans available, and
 9 health insurance issuers offering group health insurance
 10 coverage offered, to small employers that are more strin-
 11 gent than the standards under this section, except that
 12 a State may not implement standards that prevent the of-
 13 fering of at least one group health plan that provides
 14 standard coverage (as described in section 721A(b)).

15 **“SEC. 721C. RATING LIMITATIONS FOR COMMUNITY-RATED**
 16 **MARKET.**

17 “(a) STANDARD PREMIUMS WITH RESPECT TO COM-
 18 MUNITY-RATED ELIGIBLE EMPLOYEES AND ELIGIBLE IN-
 19 DIVIDUALS.—

20 “(1) IN GENERAL.—Each group health plan of-
 21 fered, and each health insurance issuer offering
 22 group health insurance coverage, to a small em-
 23 ployer shall establish within each community rating
 24 area in which the plan is to be offered, a standard
 25 premium for enrollment of eligible employees and eli-

gible individuals for the standard coverage (as defined under section 721A(b)).

“(2) ESTABLISHMENT OF COMMUNITY RATING AREA.—

“(A) IN GENERAL.—Not later than January 1, 2000, each State shall, in accordance with subparagraph (B), provide for the division of the State into 1 or more community rating areas. The State may revise the boundaries of such areas from time to time consistent with this paragraph.

“(B) GEOGRAPHIC AREA VARIATIONS.—
For purposes of subparagraph (A), a State—

“(i) may not identify an area that divides a 3-digit zip code, a county, or all portions of a metropolitan statistical area;

“(ii) shall not permit premium rates for coverage offered in a portion of an interstate metropolitan statistical area to vary based on the State in which the coverage is offered; and

“(iii) may, upon agreement with one or more adjacent States, identify multi-State geographic areas consistent with clauses (i) and (ii).

1 “(3) ELIGIBLE INDIVIDUALS.—For purposes of
 2 this section, the term ‘eligible individuals’ includes
 3 certain uninsured individuals (as described in section
 4 721G).

5 “(b) UNIFORM PREMIUMS WITHIN COMMUNITY RAT-
 6 ING AREAS.—

7 “(1) IN GENERAL.—Subject to paragraphs (2)
 8 and (3), the standard premium for each group
 9 health plan to which this section applies shall be the
 10 same, but shall not include the costs of premium
 11 processing and enrollment that may vary depending
 12 on whether the method of enrollment is through a
 13 qualified small employer purchasing group, through
 14 a small employer, or through a broker.

15 “(2) APPLICATION TO ENROLLEES.—

16 “(A) IN GENERAL.—The premium charged
 17 for coverage in a group health plan which cov-
 18 ers eligible employees and eligible individuals
 19 shall be the product of—

20 “(i) the standard premium (estab-
 21 lished under paragraph (1));

22 “(ii) in the case of enrollment other
 23 than individual enrollment, the family ad-
 24 justment factor specified under subpara-
 25 graph (B); and

1 “(iii) the age adjustment factor (spec-
 2 ified under subparagraph (C)).

3 “(B) FAMILY ADJUSTMENT FACTOR.—

4 “(i) IN GENERAL.—The standards es-
 5 tablished under section 721B shall specify
 6 family adjustment factors that reflect the
 7 relative actuarial costs of benefit packages
 8 based on family classes of enrollment (as
 9 compared with such costs for individual en-
 10 rollment).

11 “(ii) CLASSES OF ENROLLMENT.—For
 12 purposes of this subpart, there are 4 class-
 13 es of enrollment:

14 “(I) Coverage only of an individ-
 15 ual (referred to in this subpart as the
 16 ‘individual’ enrollment or class of en-
 17 rollment).

18 “(II) Coverage of a married cou-
 19 ple without children (referred to in
 20 this subpart as the ‘couple-only’ en-
 21 rollment or class of enrollment).

22 “(III) Coverage of an individual
 23 and one or more children (referred to
 24 in this subpart as the ‘single parent’
 25 enrollment or class of enrollment).

1 “(IV) Coverage of a married cou-
 2 ple and one or more children (referred
 3 to in this subpart as the ‘dual parent’
 4 enrollment or class of enrollment).

5 “(iii) REFERENCES TO FAMILY AND
 6 COUPLE CLASSES OF ENROLLMENT.—In
 7 this subpart:

8 “(I) FAMILY.—The terms ‘family
 9 enrollment’ and ‘family class of enroll-
 10 ment’ refer to enrollment in a class of
 11 enrollment described in any subclause
 12 of clause (ii) (other than subclause
 13 (I)).

14 “(II) COUPLE.—The term ‘couple
 15 class of enrollment’ refers to enroll-
 16 ment in a class of enrollment de-
 17 scribed in subclause (II) or (IV) of
 18 clause (ii).

19 “(iv) SPOUSE; MARRIED; COUPLE.—

20 “(I) IN GENERAL.—In this sub-
 21 part, the terms ‘spouse’ and ‘married’
 22 mean, with respect to an individual,
 23 another individual who is the spouse
 24 of, or is married to, the individual, as

1 determined under applicable State
2 law.

3 “(II) COUPLE.—The term ‘cou-
4 ple’ means an individual and the indi-
5 vidual’s spouse.

6 “(C) AGE ADJUSTMENT FACTOR.—The
7 Secretary, in consultation with the NAIC, shall
8 specify uniform age categories and maximum
9 rating increments for age adjustment factors
10 that reflect the relative actuarial costs of bene-
11 fit packages among enrollees. For individuals
12 who have attained age 18 but not age 65, the
13 highest age adjustment factor may not exceed 3
14 times the lowest age adjustment factor.

15 “(3) ADMINISTRATIVE CHARGES.—

16 “(A) IN GENERAL.—In accordance with
17 the standards established under section 721B, a
18 group health plan which covers eligible employ-
19 ees and eligible individuals may add a sepa-
20 rately-stated administrative charge which is
21 based on identifiable differences in legitimate
22 administrative costs and which is applied uni-
23 formly for individuals enrolling through the
24 same method of enrollment. Nothing in this
25 subparagraph may be construed as preventing a

1 qualified small employer purchasing group from
 2 negotiating a unique administrative charge with
 3 an insurer for a group health plan.

4 “(B) ENROLLMENT THROUGH A QUALI-
 5 FIED SMALL EMPLOYER PURCHASING GROUP.—

6 In the case of an administrative charge under
 7 subparagraph (A) for enrollment through a
 8 qualified small employer purchasing group, such
 9 charge may not exceed the lowest charge of
 10 such plan for enrollment other than through a
 11 qualified small employer purchasing group in
 12 such area.

13 “(c) TREATMENT OF NEGOTIATED RATE AS COMMU-
 14 NITY RATE.—Notwithstanding any other provision of this
 15 section, a group health plan and a health insurance issuer
 16 offering health insurance coverage that negotiates a pre-
 17 mium rate (exclusive of any administrative charge de-
 18 scribed in subsection (b)(3)) with a qualified small em-
 19 ployer purchasing group in a community rating area shall
 20 charge the same premium rate to all eligible employees
 21 and eligible individuals.

22 **“SEC. 721D. RATING PRACTICES AND PAYMENT OF PRE-**
 23 **MIUMS.**

24 “(a) FULL DISCLOSURE OF RATING PRACTICES.—

1 “(1) IN GENERAL.—A group health plan and a
 2 health insurance issuer offering health insurance
 3 coverage shall fully disclose rating practices for the
 4 plan to the appropriate certifying authority.

5 “(2) NOTICE ON EXPIRATION.—A group health
 6 plan and a health insurance issuer offering health
 7 insurance coverage shall provide for notice of the
 8 terms for renewal of a plan at the time of the offer-
 9 ing of the plan and at least 90 days before the date
 10 of expiration of the plan.

11 “(3) ACTUARIAL CERTIFICATION.—Each group
 12 health plan and health insurance issuer offering
 13 health insurance coverage shall file annually with the
 14 appropriate certifying authority a written statement
 15 by a member of the American Academy of Actuaries
 16 (or other individual acceptable to such authority)
 17 who is not an employee of the group health plan or
 18 issuer certifying that, based upon an examination by
 19 the individual which includes a review of the appro-
 20 priate records and of the actuarial assumptions of
 21 such plan or insurer and methods used by the plan
 22 or insurer in establishing premium rates and admin-
 23 istrative charges for group health plans—

1 “(A) such plan or insurer is in compliance
 2 with the applicable provisions of this subpart;
 3 and

4 “(B) the rating methods are actuarially
 5 sound.

6 Each plan and insurer shall retain a copy of such
 7 statement at its principal place of business for exam-
 8 ination by any individual.

9 “(b) PAYMENT OF PREMIUMS.—

10 “(1) IN GENERAL.—With respect to a new en-
 11 rollee in a group health plan, the plan may require
 12 advanced payment of an amount equal to the month-
 13 ly applicable premium for the plan at the time such
 14 individual is enrolled.

15 “(2) NOTIFICATION OF FAILURE TO RECEIVE
 16 PREMIUM.—If a group health plan or a health insur-
 17 ance issuer offering health insurance coverage fails
 18 to receive payment on a premium due with respect
 19 to an eligible employee or eligible individual covered
 20 under the plan involved, the plan or issuer shall pro-
 21 vide notice of such failure to the employee or individ-
 22 ual within the 20-day period after the date on which
 23 such premium payment was due. A plan or issuer
 24 may not terminate the enrollment of an eligible em-
 25 ployee or eligible individual unless such employee or

1 individual has been notified of any overdue pre-
 2 miums and has been provided a reasonable oppor-
 3 tunity to respond to such notice.

4 **“SEC. 721E. QUALIFIED SMALL EMPLOYER PURCHASING**
 5 **GROUPS.**

6 “(a) QUALIFIED SMALL EMPLOYER PURCHASING
 7 GROUPS DESCRIBED.—

8 “(1) IN GENERAL.—A qualified small employer
 9 purchasing group is an entity that—

10 “(A) is a nonprofit entity certified under
 11 State law;

12 “(B) has a membership consisting solely of
 13 small employers;

14 “(C) is administered solely under the au-
 15 thority and control of its member employers;

16 “(D) with respect to each State in which
 17 its members are located, consists of not fewer
 18 than the number of small employers established
 19 by the State as appropriate for such a group;

20 “(E) offers a program under which quali-
 21 fied group health plans are offered to eligible
 22 employees and eligible individuals through its
 23 member employers and to certain uninsured in-
 24 dividuals in accordance with section 721D; and

1 “(F) an insurer, agent, broker, or any
 2 other individual or entity engaged in the sale of
 3 insurance—

4 “(i) does not form or underwrite; and

5 “(ii) does not hold or control any
 6 right to vote with respect to.

7 “(2) STATE CERTIFICATION.—A qualified small
 8 employer purchasing group formed under this sec-
 9 tion shall submit an application to the State for cer-
 10 tification. The State shall determine whether to
 11 issue a certification and otherwise ensure compliance
 12 with the requirements of this subpart.

13 “(3) SPECIAL RULE.—Notwithstanding para-
 14 graph (1)(B), an employer member of a small em-
 15 ployer purchasing group that has been certified by
 16 the State as meeting the requirements of paragraph
 17 (1) may retain its membership in the group if the
 18 number of employees of the employer increases such
 19 that the employer is no longer a small employer.

20 “(b) BOARD OF DIRECTORS.—Each qualified small
 21 employer purchasing group established under this section
 22 shall be governed by a board of directors or have active
 23 input from an advisory board consisting of individuals and
 24 businesses participating in the group.

1 “(c) DOMICILIARY STATE.—For purposes of this sec-
2 tion, a qualified small employer purchasing group operat-
3 ing in more than one State shall be certified by the State
4 in which the group is domiciled.

5 “(d) MEMBERSHIP.—

6 “(1) IN GENERAL.—A qualified small employer
7 purchasing group shall accept all small employers
8 and certain uninsured individuals residing within the
9 area served by the group as members if such em-
10 ployers or individuals request such membership.

11 “(2) VOTING.—Members of a qualified small
12 employer purchasing group shall have voting rights
13 consistent with the rules established by the State.

14 “(e) DUTIES OF QUALIFIED SMALL EMPLOYER PUR-
15 CHASING GROUPS.—Each qualified small employer pur-
16 chasing group shall—

17 “(1) enter into agreements with insurers offer-
18 ing qualified group health plans;

19 “(2) enter into agreements with small employ-
20 ers under section 721F;

21 “(3) enroll only eligible employees, eligible indi-
22 viduals, and certain uninsured individuals in quali-
23 fied group health plans, in accordance with section
24 721G;

25 “(4) provide enrollee information to the State;

1 “(5) meet the marketing requirements under
2 section 721I; and

3 “(6) carry out other functions provided for
4 under this subpart.

5 “(f) LIMITATION ON ACTIVITIES.—A qualified small
6 employer purchasing group shall not—

7 “(1) perform any activity involving approval or
8 enforcement of payment rates for providers;

9 “(2) perform any activity (other than the re-
10 porting of noncompliance) relating to compliance of
11 qualified group health plans with the requirements
12 of this subpart;

13 “(3) assume financial risk in relation to any
14 such health plan; or

15 “(4) perform other activities identified by the
16 State as being inconsistent with the performance of
17 its duties under this subpart.

18 “(g) RULES OF CONSTRUCTION.—

19 “(1) ESTABLISHMENT NOT REQUIRED.—Noth-
20 ing in this section shall be construed as requiring—

21 “(A) that a State organize, operate or oth-
22 erwise establish a qualified small employer pur-
23 chasing group, or otherwise require the estab-
24 lishment of purchasing groups; and

1 “(B) that there be only one qualified small
 2 employer purchasing group established with re-
 3 spect to a community rating area.

4 “(2) SINGLE ORGANIZATION SERVING MUL-
 5 TIPLE AREAS AND STATES.—Nothing in this section
 6 shall be construed as preventing a single entity from
 7 being a qualified small employer purchasing group in
 8 more than one community rating area or in more
 9 than one State.

10 “(3) VOLUNTARY PARTICIPATION.—Nothing in
 11 this section shall be construed as requiring any indi-
 12 vidual or small employer to purchase a qualified
 13 group health plan exclusively through a qualified
 14 small employer purchasing group.

15 **“SEC. 721F. AGREEMENTS WITH SMALL EMPLOYERS.**

16 “(a) IN GENERAL.—A qualified small employer pur-
 17 chasing group shall offer to enter into an agreement under
 18 this section with each small employer that employs eligible
 19 employees in the area served by the group.

20 “(b) PAYROLL DEDUCTION.—

21 “(1) IN GENERAL.—Under an agreement under
 22 this section between a small employer and a quali-
 23 fied small employer purchasing group, the small em-
 24 ployer shall deduct premiums from an eligible em-
 25 ployee’s wages.

1 “(2) ADDITIONAL PREMIUMS.—If the amount
 2 withheld under paragraph (1) is not sufficient to
 3 cover the entire cost of the premiums, the eligible
 4 employee shall be responsible for paying directly to
 5 the qualified small employer purchasing group the
 6 difference between the amount of such premiums
 7 and the amount withheld.

8 **“SEC. 721G. ENROLLING ELIGIBLE EMPLOYEES, ELIGIBLE**
 9 **INDIVIDUALS, AND CERTAIN UNINSURED IN-**
 10 **DIVIDUALS IN QUALIFIED GROUP HEALTH**
 11 **PLANS.**

12 “(a) IN GENERAL.—Each qualified small employer
 13 purchasing group shall offer—

14 “(1) eligible employees,

15 “(2) eligible individuals, and

16 “(3) certain uninsured individuals,

17 the opportunity to enroll in any qualified group health
 18 plan which has an agreement with the qualified small em-
 19 ployer purchasing group for the community rating area
 20 in which such employees and individuals reside.

21 “(b) UNINSURED INDIVIDUALS.—For purposes of
 22 this section, an individual is described in subsection (a)(3)
 23 if such individual is an uninsured individual who is not
 24 an eligible employee of a small employer that is a member

1 of a qualified small employer purchasing group or a de-
2 pendent of such individual.

3 **“SEC. 721H. RECEIPT OF PREMIUMS.**

4 “(a) ENROLLMENT CHARGE.—The amount charged
5 by a qualified small employer purchasing group for cov-
6 erage under a qualified group health plan shall be equal
7 to the sum of—

8 “(1) the premium rate offered by such health
9 plan;

10 “(2) the administrative charge for such health
11 plan; and

12 “(3) the purchasing group administrative
13 charge for enrollment of eligible employees, eligible
14 individuals and certain uninsured individuals
15 through the group.

16 “(b) DISCLOSURE OF PREMIUM RATES AND ADMIN-
17 ISTRATIVE CHARGES.—Each qualified small employer
18 purchasing group shall, prior to the time of enrollment,
19 disclose to enrollees and other interested parties the pre-
20 mium rate for a qualified group health plan, the adminis-
21 trative charge for such plan, and the administrative charge
22 of the group, separately.

23 **“SEC. 721I. MARKETING ACTIVITIES.**

24 “Each qualified small employer purchasing group
25 shall market qualified group health plans to members

1 through the entire community rating area served by the
 2 purchasing group.

3 **“SEC. 721J. GRANTS TO STATES AND QUALIFIED SMALL EM-**
 4 **PLOYER PURCHASING GROUPS.**

5 “(a) IN GENERAL.—The Secretary shall award
 6 grants to States and small employer purchasing groups
 7 to assist such States and groups in planning, developing,
 8 and operating qualified small employer purchasing groups.

9 “(b) APPLICATION REQUIREMENTS.—To be eligible
 10 to receive a grant under this section, a State or small em-
 11 ployer purchasing group shall prepare and submit to the
 12 Secretary an application in such form, at such time, and
 13 containing such information, certifications, and assur-
 14 ances as the Secretary shall reasonably require.

15 “(c) USE OF FUNDS.—Amounts awarded under this
 16 section may be used to finance the costs associated with
 17 planning, developing, and operating a qualified small em-
 18 ployer purchasing group. Such costs may include the costs
 19 associated with—

20 “(1) engaging in education and outreach efforts
 21 to inform small employers, insurers, and the public
 22 about the small employer purchasing group;

23 “(2) soliciting bids and negotiating with insur-
 24 ers to make available group health plans;

1 “(3) preparing the documentation required to
 2 receive certification by the Secretary as a qualified
 3 small employer purchasing group; and

4 “(4) such other activities determined appro-
 5 priate by the Secretary.

6 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
 7 are authorized to be appropriated for awarding grants
 8 under this section such sums as may be necessary.

9 **“SEC. 721K. QUALIFIED SMALL EMPLOYER PURCHASING**
 10 **GROUPS ESTABLISHED BY A STATE.**

11 “A State may establish a system in all or part of the
 12 State under which qualified small employer purchasing
 13 groups are the sole mechanism through which health care
 14 coverage for the eligible employees of small employers shall
 15 be purchased or provided.

16 **“SEC. 721L. EFFECTIVE DATES.**

17 “(a) IN GENERAL.—Except as provided in this chap-
 18 ter, the provisions of this chapter are effective on the date
 19 of the enactment of this subpart.

20 “(b) EXCEPTION.—The provisions of section 721C(b)
 21 shall apply to contracts which are issued, or renewed, after
 22 the date which is 18 months after the date of the enact-
 23 ment of this subpart.

1 **“CHAPTER 2—REQUIRED COVERAGE OPTIONS**
2 **FOR ELIGIBLE EMPLOYEES AND DEPEND-**
3 **ENTS OF SMALL EMPLOYERS**

4 **“SEC. 722. REQUIRING SMALL EMPLOYERS TO OFFER COV-**
5 **ERAGE FOR ELIGIBLE INDIVIDUALS.**

6 “(a) REQUIREMENT TO OFFER.—Each small em-
7 ployer shall make available with respect to each eligible
8 employee a group health plan under which—

9 “(1) coverage of each eligible individual with re-
10 spect to such an eligible employee may be elected on
11 an annual basis for each plan year;

12 “(2) coverage is provided for at least the stand-
13 ard coverage specified in section 721A(b); and

14 “(3) each eligible employee electing such cov-
15 erage may elect to have any premiums owed by the
16 employee collected through payroll deduction.

17 “(b) NO EMPLOYER CONTRIBUTION REQUIRED.—An
18 employer is not required under subsection (a) to make any
19 contribution to the cost of coverage under a group health
20 plan described in such subsection.

21 “(c) SPECIAL RULES.—

22 “(1) EXCLUSION OF NEW EMPLOYERS AND
23 CERTAIN VERY SMALL EMPLOYERS.—Subsection (a)
24 shall not apply to any small employer for any plan
25 year if, as of the beginning of such plan year—

1 “(A) such employer (including any prede-
2 cessor thereof) has been an employer for less
3 than 2 years;

4 “(B) such employer has no more than 2 el-
5 igible employees; or

6 “(C) no more than 2 eligible employees are
7 not covered under any group health plan.

8 “(2) EXCLUSION OF FAMILY MEMBERS.—Under
9 such procedures as the Secretary may prescribe, any
10 relative of a small employer may be, at the election
11 of the employer, excluded from consideration as an
12 eligible employee for purposes of applying the re-
13 quirements of subsection (a). In the case of a small
14 employer that is not an individual, an employee who
15 is a relative of a key employee (as defined in section
16 416(i)(1) of the Internal Revenue Code of 1986) of
17 the employer may, at the election of the key em-
18 ployee, be considered a relative excludable under this
19 paragraph.

20 “(3) OPTIONAL APPLICATION OF WAITING PE-
21 RIOD.—A group health plan and a health insurance
22 issuer offering group health insurance coverage shall
23 not be treated as failing to meet the requirements of
24 subsection (a) solely because a period of service by
25 an eligible employee of not more than 60 days is re-

1 quired under the plan for coverage under the plan
 2 of eligible individuals with respect to such employee.

3 “(d) CONSTRUCTION.—Nothing in this section shall
 4 be construed as limiting the group health plans, or types
 5 of coverage under such a plan, that an employer may offer
 6 to an employee.

7 **“SEC. 722A. COMPLIANCE WITH APPLICABLE REQUIRE-**
 8 **MENTS THROUGH MULTIPLE EMPLOYER**
 9 **HEALTH ARRANGEMENTS.**

10 “(a) IN GENERAL.—In any case in which an eligible
 11 employee is, for any plan year, a participant in a group
 12 health plan which is a multiemployer plan, the require-
 13 ments of section 722(a) shall be deemed to be met with
 14 respect to such employee for such plan year if the em-
 15 ployer requirements of subsection (b) are met with respect
 16 to the eligible employee, irrespective of whether, or to what
 17 extent, the employer makes employer contributions on be-
 18 half of the eligible employee.

19 “(b) EMPLOYER REQUIREMENTS.—The employer re-
 20 quirements of this subsection are met under a group
 21 health plan with respect to an eligible employee if—

22 “(1) the employee is eligible under the plan to
 23 elect coverage on an annual basis and is provided a
 24 reasonable opportunity to make the election in such

1 form and manner and at such times as are provided
 2 by the plan;

3 “(2) coverage is provided for at least the stand-
 4 ard coverage specified in section 721A(b);

5 “(3) the employer facilitates collection of any
 6 employee contributions under the plan and permits
 7 the employee to elect to have employee contributions
 8 under the plan collected through payroll deduction;
 9 and

10 “(4) in the case of a plan to which part 1 does
 11 not otherwise apply, the employer provides to the
 12 employee a summary plan description described in
 13 section 102(a)(1) in the form and manner and at
 14 such times as are required under such part 1 with
 15 respect to employee welfare benefit plans.

16 **“CHAPTER 3—REQUIRED COVERAGE OPTIONS**
 17 **FOR INDIVIDUALS INSURED THROUGH ASSO-**
 18 **CIATION PLANS**

19 **“Subchapter A—Qualified Association Plans**

20 **“SEC. 723. TREATMENT OF QUALIFIED ASSOCIATION**
 21 **PLANS.**

22 “(a) GENERAL RULE.—For purposes of this chapter,
 23 in the case of a qualified association plan—

24 “(1) except as otherwise provided in this sub-
 25 chapter, the plan shall meet all applicable require-

1 ments of chapter 1 and chapter 2 for group health
2 plans offered to and by small employers;

3 “(2) if such plan is certified as meeting such
4 requirements and the requirements of this sub-
5 chapter, such plan shall be treated as a plan estab-
6 lished and maintained by a small employer, and indi-
7 viduals enrolled in such plan shall be treated as eli-
8 gible employees; and

9 “(3) any individual who is a member of the as-
10 sociation not enrolling in the plan shall not be treat-
11 ed as an eligible employee solely by reason of mem-
12 bership in such association.

13 “(b) ELECTION TO BE TREATED AS PURCHASING
14 COOPERATIVE.—Subsection (a) shall not apply to a quali-
15 fied association plan if—

16 “(1) the health insurance issuer makes an irrev-
17 ocable election to be treated as a qualified small em-
18 ployer purchasing group for purposes of section
19 721D; and

20 “(2) such sponsor meets all requirements of
21 this subpart applicable to a purchasing cooperative.

22 **“SEC. 723A. QUALIFIED ASSOCIATION PLAN DEFINED.**

23 “(a) GENERAL RULE.—For purposes of this chapter,
24 a plan is a qualified association plan if the plan is a mul-

1 tiple employer welfare arrangement or similar
2 arrangement—

3 “(1) which is maintained by a qualified associa-
4 tion;

5 “(2) which has at least 500 participants in the
6 United States;

7 “(3) under which the benefits provided consist
8 solely of medical care (as defined in section 213(d)
9 of the Internal Revenue Code of 1986);

10 “(4) which may not condition participation in
11 the plan, or terminate coverage under the plan, on
12 the basis of the health status or health claims expe-
13 rience of any employee or member or dependent of
14 either;

15 “(5) which provides for bonding, in accordance
16 with regulations providing rules similar to the rules
17 under section 412, of all persons operating or ad-
18 ministering the plan or involved in the financial af-
19 fairs of the plan; and

20 “(6) which notifies each participant or provider
21 that it is certified as meeting the requirements of
22 this chapter applicable to it.

23 “(b) SELF-INSURED PLANS.—In the case of a plan
24 which is not fully insured (within the meaning of section

1 514(b)(6)(D)), the plan shall be treated as a qualified as-
 2 sociation plan only if—

3 “(1) the plan meets minimum financial solvency
 4 and cash reserve requirements for claims which are
 5 established by the Secretary and which shall be in
 6 lieu of any other such requirements under this chap-
 7 ter;

8 “(2) the plan provides an annual funding report
 9 (certified by an independent actuary) and annual fi-
 10 nancial statements to the Secretary and other inter-
 11 ested parties; and

12 “(3) the plan appoints a plan sponsor who is
 13 responsible for operating the plan and ensuring com-
 14 pliance with applicable Federal and State laws.

15 “(c) CERTIFICATION.—

16 “(1) IN GENERAL.—A plan shall not be treated
 17 as a qualified association plan for any period unless
 18 there is in effect a certification by the Secretary that
 19 the plan meets the requirements of this subchapter.
 20 For purposes of this chapter, the Secretary shall be
 21 the appropriate certifying authority with respect to
 22 the plan.

23 “(2) FEE.—The Secretary shall require a
 24 \$5,000 fee for the original certification under para-
 25 graph (1) and may charge a reasonable annual fee

1 to cover the costs of processing and reviewing the
2 annual statements of the plan.

3 “(3) EXPEDITED PROCEDURES.—The Secretary
4 may by regulation provide for expedited registration,
5 certification, and comment procedures.

6 “(4) AGREEMENTS.—The Secretary of Labor
7 may enter into agreements with the States to carry
8 out the Secretary’s responsibilities under this sub-
9 chapter.

10 “(d) AVAILABILITY.—Notwithstanding any other
11 provision of this chapter, a qualified association plan may
12 limit coverage to individuals who are members of the
13 qualified association establishing or maintaining the plan,
14 an employee of such member, or a dependent of either.

15 “(e) SPECIAL RULES FOR EXISTING PLANS.—In the
16 case of a plan in existence on January 1, 1999—

17 “(1) the requirements of subsection (a) (other
18 than paragraphs (4), (5), and (6) thereof) shall not
19 apply;

20 “(2) no original certification shall be required
21 under this subchapter; and

22 “(3) no annual report or funding statement
23 shall be required before January 1, 2001, but the
24 plan shall file with the Secretary a description of the
25 plan and the name of the health insurance issuer.

1 **“SEC. 723B. DEFINITIONS AND SPECIAL RULES.**

2 “(a) QUALIFIED ASSOCIATION.—For purposes of this
3 subchapter, the term ‘qualified association’ means any or-
4 ganization which—

5 “(1) is organized and maintained in good faith
6 by a trade association, an industry association, a
7 professional association, a chamber of commerce, a
8 religious organization, a public entity association, or
9 other business association serving a common or simi-
10 lar industry;

11 “(2) is organized and maintained for substan-
12 tial purposes other than to provide a health plan;

13 “(3) has a constitution, bylaws, or other similar
14 governing document which states its purpose; and

15 “(4) receives a substantial portion of its finan-
16 cial support from its active, affiliated, or federation
17 members.

18 “(b) COORDINATION.—The term ‘qualified associa-
19 tion plan’ shall not include a plan to which subchapter
20 B applies.

1 **“Subchapter B—Special Rule for Church,**
 2 **Multiemployer, and Cooperative Plans**

3 **“SEC. 723F. SPECIAL RULE FOR CHURCH, MULTIEM-**
 4 **PLOYER, AND COOPERATIVE PLANS.**

5 “(a) GENERAL RULE.—For purposes of this chapter,
 6 in the case of a group health plan to which this section
 7 applies—

8 “(1) except as otherwise provided in this sub-
 9 chapter, the plan shall be required to meet all appli-
 10 cable requirements of chapter 1 and chapter 2 for
 11 group health plans offered to and by small employ-
 12 ers;

13 “(2) if such plan is certified as meeting such
 14 requirements, such plan shall be treated as a plan
 15 established and maintained by a small employer and
 16 individuals enrolled in such plan shall be treated as
 17 eligible employees; and

18 “(3) any individual eligible to enroll in the plan
 19 who does not enroll in the plan shall not be treated
 20 as an eligible employee solely by reason of being eli-
 21 gible to enroll in the plan.

22 “(b) MODIFIED STANDARDS.—

23 “(1) CERTIFYING AUTHORITY.—For purposes
 24 of this chapter, the Secretary shall be the appro-
 25 priate certifying authority with respect to a plan to
 26 which this section applies.

1 “(2) AVAILABILITY.—Rules similar to the rules
2 of subsection (e) of section 723A shall apply to a
3 plan to which this section applies.

4 “(3) ACCESS.—An employer which, pursuant to
5 a collective bargaining agreement, offers an em-
6 ployee the opportunity to enroll in a plan described
7 in subsection (c)(2) shall not be required to make
8 any other plan available to the employee.

9 “(4) TREATMENT UNDER STATE LAWS.—A
10 church plan described in subsection (c)(1) which is
11 certified as meeting the requirements of this section
12 shall not be deemed to be a multiple employer wel-
13 fare arrangement or an insurance company or other
14 insurer, or to be engaged in the business of insur-
15 ance, for purposes of any State law purporting to
16 regulate insurance companies or insurance contracts.

17 “(c) PLANS TO WHICH SECTION APPLIES.—This sec-
18 tion shall apply to a health plan which—

19 “(1) is a church plan (as defined in section
20 414(e) of the Internal Revenue Code of 1986) which
21 has at least 100 participants in the United States;

22 “(2) is a multiemployer plan which is main-
23 tained by a health plan sponsor described in section
24 3(16)(B)(iii) and which has at least 500 participants
25 in the United States; or

1 “(3) is a plan which is maintained by a rural
2 electric cooperative or a rural telephone cooperative
3 association and which has at least 500 participants
4 in the United States.”.

5 (b) CONFORMING AMENDMENTS.—Section 731(d) of
6 the Employee Retirement Income Security Act of 1974
7 (29 U.S.C. 1186(d)) is amended by adding at the end the
8 following:

9 “(3) ELIGIBLE EMPLOYEE.—The term ‘eligible
10 employee’ means, with respect to an employer, an
11 employee who normally performs on a monthly basis
12 at least 30 hours of service per week for that em-
13 ployer.

14 “(4) ELIGIBLE INDIVIDUAL.—The term ‘eligible
15 individual’ means, with respect to an eligible em-
16 ployee, such employee, and any dependent of such
17 employee.

18 “(5) NAIC.—The term ‘NAIC’ means the Na-
19 tional Association of Insurance Commissioners.

20 “(6) QUALIFIED GROUP HEALTH PLAN.—The
21 term ‘qualified group health plan’ shall have the
22 meaning given the term in section 721.”.

1 **SEC. 302. AMENDMENTS TO THE PUBLIC HEALTH SERVICE**

2 **ACT RELATING TO THE GROUP MARKET.**

3 (a) IN GENERAL.—Subpart 2 of part A of title
4 XXVII of the Public Health Service Act (42 U.S.C.
5 300gg-4 et seq.) is amended—

6 (1) by inserting after the subpart heading the
7 following:

8 **“CHAPTER 1—MISCELLANEOUS REQUIREMENTS”;**

9 and

10 (2) by adding at the end the following:

11 **“CHAPTER 2—GENERAL INSURANCE COVERAGE**

12 **REFORMS**

13 **“Subchapter A—Increased Availability and**

14 **Continuity of Health Coverage**

15 **“SEC. 2707. DEFINITION.**

16 “As used in this chapter, the term ‘qualified group
17 health plan’ means a group health plan, and a health in-
18 surance issuer offering group health insurance coverage,
19 that is designed to provide standard coverage (consistent
20 with section 2707A(b)).

21 **“SEC. 2707A. ACTUARIAL EQUIVALENCE IN BENEFITS PER-**
22 **MITTED.**

23 **“(a) SET OF RULES OF ACTUARIAL EQUIVALENCE.—**

24 **“(1) INITIAL DETERMINATION.—**The NAIC is
25 requested to submit to the Secretary, within 6
26 months after the date of the enactment of this chap-

1 ter, a set of rules which the NAIC determines is suf-
 2 ficient for determining, in the case of any group
 3 health plan, or a health insurance issuer offering
 4 group health insurance coverage, and for purposes of
 5 this section, the actuarial value of the coverage of-
 6 fered by the plan or coverage.

7 “(2) CERTIFICATION.—If the Secretary deter-
 8 mines that the NAIC has submitted a set of rules
 9 that comply with the requirements of paragraph (1),
 10 the Secretary shall certify such set of rules for use
 11 under this chapter. If the Secretary determines that
 12 such a set of rules has not been submitted or does
 13 not comply with such requirements, the Secretary
 14 shall promptly establish a set of rules that meets
 15 such requirements.

16 “(b) STANDARD COVERAGE.—

17 “(1) IN GENERAL.—A a group health plan, and
 18 a health insurance issuer offering group health in-
 19 surance coverage, shall be considered to provide
 20 standard coverage consistent with this subsection if
 21 the benefits are determined, in accordance with the
 22 set of actuarial equivalence rules certified under sub-
 23 section (a), to have a value that is within 5 percent-
 24 age points of the target actuarial value for standard
 25 coverage established under paragraph (2).

1 “(2) INITIAL DETERMINATION OF TARGET AC-
2 TUARIAL VALUE FOR STANDARD COVERAGE.—

3 “(A) INITIAL DETERMINATION.—

4 “(i) IN GENERAL.—The NAIC is re-
5 quested to submit to the Secretary, within
6 6 months after the date of the enactment
7 of this chapter, a target actuarial value for
8 standard coverage equal to the average ac-
9 tuarial value of the coverage described in
10 clause (ii). No specific procedure or treat-
11 ment, or classes thereof, is required to be
12 considered in such determination by this
13 chapter or through regulations. The deter-
14 mination of such value shall be based on a
15 representative distribution of the popu-
16 lation of eligible employees offered such
17 coverage and a single set of standardized
18 utilization and cost factors.

19 “(ii) COVERAGE DESCRIBED.—The
20 coverage described in this clause is cov-
21 erage for medically necessary and appro-
22 priate services consisting of medical and
23 surgical services, medical equipment, pre-
24 ventive services, and emergency transpor-
25 tation in frontier areas. No specific proce-

1 dure or treatment, or classes thereof, is re-
 2 quired to be covered in such a plan, by this
 3 chapter or through regulations.

4 “(B) CERTIFICATION.—If the Secretary
 5 determines that the NAIC has submitted a tar-
 6 get actuarial value for standard coverage that
 7 complies with the requirements of subparagraph
 8 (A), the Secretary shall certify such value for
 9 use under this chapter. If the Secretary deter-
 10 mines that a target actuarial value has not been
 11 submitted or does not comply with the require-
 12 ments of subparagraph (A), the Secretary shall
 13 promptly determine a target actuarial value
 14 that meets such requirements.

15 “(c) SUBSEQUENT REVISIONS.—

16 “(1) NAIC.—The NAIC may submit from time
 17 to time to the Secretary revisions of the set of rules
 18 of actuarial equivalence and target actuarial values
 19 previously established or determined under this sec-
 20 tion if the NAIC determines that revisions are nec-
 21 essary to take into account changes in the relevant
 22 types of health benefits provisions or in demographic
 23 conditions which form the basis for the set of rules
 24 of actuarial equivalence or the target actuarial val-
 25 ues. The provisions of subsection (a)(2) shall apply

1 to such a revision in the same manner as they apply
 2 to the initial determination of the set of rules.

3 “(2) SECRETARY.—The Secretary may by regu-
 4 lation revise the set of rules of actuarial equivalence
 5 and target actuarial values from time to time if the
 6 Secretary determines such revisions are necessary to
 7 take into account changes described in paragraph
 8 (1).

9 **“SEC. 2707B. ESTABLISHMENT OF PLAN STANDARDS.**

10 “(a) ESTABLISHMENT OF GENERAL STANDARDS.—

11 “(1) ROLE OF NAIC.—The NAIC is requested
 12 to submit to the Secretary, within 9 months after
 13 the date of the enactment of this chapter, model reg-
 14 ulations that specify standards for making qualified
 15 group health plans available to small employers. If
 16 the NAIC develops recommended regulations specify-
 17 ing such standards within such period, the Secretary
 18 shall review the standards. Such review shall be
 19 completed within 60 days after the date the regula-
 20 tions are developed. Such standards shall serve as
 21 the standards under this section, with such amend-
 22 ments as the Secretary deems necessary. Such
 23 standards shall be nonbinding (except as provided in
 24 chapter 4).

1 “(2) CONTINGENCY.—If the NAIC does not de-
2 velop such model regulations within the period de-
3 scribed in paragraph (1), the Secretary shall specify,
4 within 15 months after the date of the enactment of
5 this chapter, model regulations that specify stand-
6 ards for insurers with regard to making qualified
7 group health plans available to small employers.
8 Such standards shall be nonbinding (except as pro-
9 vided in chapter 4).

10 “(3) EFFECTIVE DATE.—The standards speci-
11 fied in the model regulations shall apply to group
12 health plans and health insurance issuers offering
13 group health insurance coverage in a State on or
14 after the respective date the standards are imple-
15 mented in the State.

16 “(b) NO PREEMPTION OF STATE LAW.—A State may
17 implement standards for group health plans available, and
18 health insurance issuers offering group health insurance
19 coverage offered, to small employers that are more strin-
20 gent than the standards under this section, except that
21 a State may not implement standards that prevent the of-
22 fering of at least one group health plan that provides
23 standard coverage (as described in section 2707A(b)).

1 **“SEC. 2707C. RATING LIMITATIONS FOR COMMUNITY-**
2 **RATED MARKET.**

3 “(a) STANDARD PREMIUMS WITH RESPECT TO COM-
4 MUNITY-RATED ELIGIBLE EMPLOYEES AND ELIGIBLE IN-
5 DIVIDUALS.—

6 “(1) IN GENERAL.—Each group health plan of-
7 fered, and each health insurance issuer offering
8 group health insurance coverage, to a small em-
9 ployer shall establish within each community rating
10 area in which the plan is to be offered, a standard
11 premium for enrollment of eligible employees and eli-
12 gible individuals for the standard coverage (as de-
13 fined under section 2707A(b)).

14 “(2) ESTABLISHMENT OF COMMUNITY RATING
15 AREA.—

16 “(A) IN GENERAL.—Not later than Janu-
17 ary 1, 2000, each State shall, in accordance
18 with subparagraph (B), provide for the division
19 of the State into 1 or more community rating
20 areas. The State may revise the boundaries of
21 such areas from time to time consistent with
22 this paragraph.

23 “(B) GEOGRAPHIC AREA VARIATIONS.—
24 For purposes of subparagraph (A), a State—

1 “(i) may not identify an area that di-
 2 vides a 3-digit zip code, a county, or all
 3 portions of a metropolitan statistical area;

4 “(ii) shall not permit premium rates
 5 for coverage offered in a portion of an
 6 interstate metropolitan statistical area to
 7 vary based on the State in which the cov-
 8 erage is offered; and

9 “(iii) may, upon agreement with one
 10 or more adjacent States, identify multi-
 11 State geographic areas consistent with
 12 clauses (i) and (ii).

13 “(3) ELIGIBLE INDIVIDUALS.—For purposes of
 14 this section, the term ‘eligible individuals’ includes
 15 certain uninsured individuals (as described in section
 16 2707G).

17 “(b) UNIFORM PREMIUMS WITHIN COMMUNITY RAT-
 18 ING AREAS.—

19 “(1) IN GENERAL.—Subject to paragraphs (2)
 20 and (3), the standard premium for each group
 21 health plan to which this section applies shall be the
 22 same, but shall not include the costs of premium
 23 processing and enrollment that may vary depending
 24 on whether the method of enrollment is through a

1 qualified small employer purchasing group, through
2 a small employer, or through a broker.

3 “(2) APPLICATION TO ENROLLEES.—

4 “(A) IN GENERAL.—The premium charged
5 for coverage in a group health plan which cov-
6 ers eligible employees and eligible individuals
7 shall be the product of—

8 “(i) the standard premium (estab-
9 lished under paragraph (1));

10 “(ii) in the case of enrollment other
11 than individual enrollment, the family ad-
12 justment factor specified under subpara-
13 graph (B); and

14 “(iii) the age adjustment factor (spec-
15 ified under subparagraph (C)).

16 “(B) FAMILY ADJUSTMENT FACTOR.—

17 “(i) IN GENERAL.—The standards es-
18 tablished under section 2707B shall specify
19 family adjustment factors that reflect the
20 relative actuarial costs of benefit packages
21 based on family classes of enrollment (as
22 compared with such costs for individual en-
23 rollment).

“(ii) CLASSES OF ENROLLMENT.—For purposes of this chapter, there are 4 classes of enrollment:

“(I) Coverage only of an individual (referred to in this chapter as the ‘individual’ enrollment or class of enrollment).

“(II) Coverage of a married couple without children (referred to in this chapter as the ‘couple-only’ enrollment or class of enrollment).

“(III) Coverage of an individual and one or more children (referred to in this chapter as the ‘single parent’ enrollment or class of enrollment).

“(IV) Coverage of a married couple and one or more children (referred to in this chapter as the ‘dual parent’ enrollment or class of enrollment).

“(iii) REFERENCES TO FAMILY AND COUPLE CLASSES OF ENROLLMENT.—In this chapter:

“(I) FAMILY.—The terms ‘family enrollment’ and ‘family class of enrollment’ refer to enrollment in a class of

1 enrollment described in any subclause
 2 of clause (ii) (other than subclause
 3 (I)).

4 “(II) COUPLE.—The term ‘couple
 5 class of enrollment’ refers to enroll-
 6 ment in a class of enrollment de-
 7 scribed in subclause (II) or (IV) of
 8 clause (ii).

9 “(iv) SPOUSE; MARRIED; COUPLE.—

10 “(I) IN GENERAL.—In this chap-
 11 ter, the terms ‘spouse’ and ‘married’
 12 mean, with respect to an individual,
 13 another individual who is the spouse
 14 of, or is married to, the individual, as
 15 determined under applicable State
 16 law.

17 “(II) COUPLE.—The term ‘cou-
 18 ple’ means an individual and the indi-
 19 vidual’s spouse.

20 “(C) AGE ADJUSTMENT FACTOR.—The
 21 Secretary, in consultation with the NAIC, shall
 22 specify uniform age categories and maximum
 23 rating increments for age adjustment factors
 24 that reflect the relative actuarial costs of bene-
 25 fit packages among enrollees. For individuals

1 who have attained age 18 but not age 65, the
2 highest age adjustment factor may not exceed 3
3 times the lowest age adjustment factor.

4 “(3) ADMINISTRATIVE CHARGES.—

5 “(A) IN GENERAL.—In accordance with
6 the standards established under section 2707B,
7 a group health plan which covers eligible em-
8 ployees and eligible individuals may add a sepa-
9 rately-stated administrative charge which is
10 based on identifiable differences in legitimate
11 administrative costs and which is applied uni-
12 formly for individuals enrolling through the
13 same method of enrollment. Nothing in this
14 subparagraph may be construed as preventing a
15 qualified small employer purchasing group from
16 negotiating a unique administrative charge with
17 an insurer for a group health plan.

18 “(B) ENROLLMENT THROUGH A QUALI-
19 FIED SMALL EMPLOYER PURCHASING GROUP.—
20 In the case of an administrative charge under
21 subparagraph (A) for enrollment through a
22 qualified small employer purchasing group, such
23 charge may not exceed the lowest charge of
24 such plan for enrollment other than through a

1 qualified small employer purchasing group in
2 such area.

3 “(c) TREATMENT OF NEGOTIATED RATE AS COMMU-
4 NITY RATE.—Notwithstanding any other provision of this
5 section, a group health plan and a health insurance issuer
6 offering health insurance coverage that negotiates a pre-
7 mium rate (exclusive of any administrative charge de-
8 scribed in subsection (b)(3)) with a qualified small em-
9 ployer purchasing group in a community rating area shall
10 charge the same premium rate to all eligible employees
11 and eligible individuals.

12 **“SEC. 2707D. RATING PRACTICES AND PAYMENT OF PRE-**
13 **MIUMS.**

14 “(a) FULL DISCLOSURE OF RATING PRACTICES.—

15 “(1) IN GENERAL.—A group health plan and a
16 health insurance issuer offering health insurance
17 coverage shall fully disclose rating practices for the
18 plan to the appropriate certifying authority.

19 “(2) NOTICE ON EXPIRATION.—A group health
20 plan and a health insurance issuer offering health
21 insurance coverage shall provide for notice of the
22 terms for renewal of a plan at the time of the offer-
23 ing of the plan and at least 90 days before the date
24 of expiration of the plan.

1 “(3) ACTUARIAL CERTIFICATION.—Each group
 2 health plan and health insurance issuer offering
 3 health insurance coverage shall file annually with the
 4 appropriate certifying authority a written statement
 5 by a member of the American Academy of Actuaries
 6 (or other individual acceptable to such authority)
 7 who is not an employee of the group health plan or
 8 issuer certifying that, based upon an examination by
 9 the individual which includes a review of the appro-
 10 priate records and of the actuarial assumptions of
 11 such plan or insurer and methods used by the plan
 12 or insurer in establishing premium rates and admin-
 13 istrative charges for group health plans—

14 “(A) such plan or insurer is in compliance
 15 with the applicable provisions of this chapter;
 16 and

17 “(B) the rating methods are actuarially
 18 sound.

19 Each plan and insurer shall retain a copy of such
 20 statement at its principal place of business for exam-
 21 ination by any individual.

22 “(b) PAYMENT OF PREMIUMS.—

23 “(1) IN GENERAL.—With respect to a new en-
 24 rollee in a group health plan, the plan may require
 25 advanced payment of an amount equal to the month-

1 ly applicable premium for the plan at the time such
 2 individual is enrolled.

3 “(2) NOTIFICATION OF FAILURE TO RECEIVE
 4 PREMIUM.—If a group health plan or a health insur-
 5 ance issuer offering health insurance coverage fails
 6 to receive payment on a premium due with respect
 7 to an eligible employee or eligible individual covered
 8 under the plan involved, the plan or issuer shall pro-
 9 vide notice of such failure to the employee or individ-
 10 ual within the 20-day period after the date on which
 11 such premium payment was due. A plan or issuer
 12 may not terminate the enrollment of an eligible em-
 13 ployee or eligible individual unless such employee or
 14 individual has been notified of any overdue pre-
 15 miums and has been provided a reasonable oppor-
 16 tunity to respond to such notice.

17 **“SEC. 2707E. QUALIFIED SMALL EMPLOYER PURCHASING**
 18 **GROUPS.**

19 “(a) QUALIFIED SMALL EMPLOYER PURCHASING
 20 GROUPS DESCRIBED.—

21 “(1) IN GENERAL.—A qualified small employer
 22 purchasing group is an entity that—

23 “(A) is a nonprofit entity certified under
 24 State law;

1 “(B) has a membership consisting solely of
2 small employers;

3 “(C) is administered solely under the au-
4 thority and control of its member employers;

5 “(D) with respect to each State in which
6 its members are located, consists of not fewer
7 than the number of small employers established
8 by the State as appropriate for such a group;

9 “(E) offers a program under which quali-
10 fied group health plans are offered to eligible
11 employees and eligible individuals through its
12 member employers and to certain uninsured in-
13 dividuals in accordance with section 2707D;
14 and

15 “(F) an insurer, agent, broker, or any
16 other individual or entity engaged in the sale of
17 insurance—

18 “(i) does not form or underwrite; and

19 “(ii) does not hold or control any
20 right to vote with respect to.

21 “(2) STATE CERTIFICATION.—A qualified small
22 employer purchasing group formed under this sec-
23 tion shall submit an application to the State for cer-
24 tification. The State shall determine whether to

1 issue a certification and otherwise ensure compliance
2 with the requirements of this chapter.

3 “(3) SPECIAL RULE.—Notwithstanding para-
4 graph (1)(B), an employer member of a small em-
5 ployer purchasing group that has been certified by
6 the State as meeting the requirements of paragraph
7 (1) may retain its membership in the group if the
8 number of employees of the employer increases such
9 that the employer is no longer a small employer.

10 “(b) BOARD OF DIRECTORS.—Each qualified small
11 employer purchasing group established under this section
12 shall be governed by a board of directors or have active
13 input from an advisory board consisting of individuals and
14 businesses participating in the group.

15 “(c) DOMICILIARY STATE.—For purposes of this sec-
16 tion, a qualified small employer purchasing group operat-
17 ing in more than one State shall be certified by the State
18 in which the group is domiciled.

19 “(d) MEMBERSHIP.—

20 “(1) IN GENERAL.—A qualified small employer
21 purchasing group shall accept all small employers
22 and certain uninsured individuals residing within the
23 area served by the group as members if such em-
24 ployers or individuals request such membership.

1 “(2) VOTING.—Members of a qualified small
 2 employer purchasing group shall have voting rights
 3 consistent with the rules established by the State.

4 “(e) DUTIES OF QUALIFIED SMALL EMPLOYER PUR-
 5 CHASING GROUPS.—Each qualified small employer pur-
 6 chasing group shall—

7 “(1) enter into agreements with insurers offer-
 8 ing qualified group health plans;

9 “(2) enter into agreements with small employ-
 10 ers under section 2707F;

11 “(3) enroll only eligible employees, eligible indi-
 12 viduals, and certain uninsured individuals in quali-
 13 fied group health plans, in accordance with section
 14 2707G;

15 “(4) provide enrollee information to the State;

16 “(5) meet the marketing requirements under
 17 section 2707I; and

18 “(6) carry out other functions provided for
 19 under this chapter.

20 “(f) LIMITATION ON ACTIVITIES.—A qualified small
 21 employer purchasing group shall not—

22 “(1) perform any activity involving approval or
 23 enforcement of payment rates for providers;

24 “(2) perform any activity (other than the re-
 25 porting of noncompliance) relating to compliance of

1 qualified group health plans with the requirements
 2 of this chapter;

3 “(3) assume financial risk in relation to any
 4 such health plan; or

5 “(4) perform other activities identified by the
 6 State as being inconsistent with the performance of
 7 its duties under this chapter.

8 “(g) RULES OF CONSTRUCTION.—

9 “(1) ESTABLISHMENT NOT REQUIRED.—Noth-
 10 ing in this section shall be construed as requiring—

11 “(A) that a State organize, operate or oth-
 12 erwise establish a qualified small employer pur-
 13 chasing group, or otherwise require the estab-
 14 lishment of purchasing groups; and

15 “(B) that there be only one qualified small
 16 employer purchasing group established with re-
 17 spect to a community rating area.

18 “(2) SINGLE ORGANIZATION SERVING MUL-
 19 TIPLE AREAS AND STATES.—Nothing in this section
 20 shall be construed as preventing a single entity from
 21 being a qualified small employer purchasing group in
 22 more than one community rating area or in more
 23 than one State.

24 “(3) VOLUNTARY PARTICIPATION.—Nothing in
 25 this section shall be construed as requiring any indi-

1 vidual or small employer to purchase a qualified
2 group health plan exclusively through a qualified
3 small employer purchasing group.

4 **“SEC. 2707F. AGREEMENTS WITH SMALL EMPLOYERS.**

5 “(a) IN GENERAL.—A qualified small employer pur-
6 chasing group shall offer to enter into an agreement under
7 this section with each small employer that employs eligible
8 employees in the area served by the group.

9 “(b) PAYROLL DEDUCTION.—

10 “(1) IN GENERAL.—Under an agreement under
11 this section between a small employer and a quali-
12 fied small employer purchasing group, the small em-
13 ployer shall deduct premiums from an eligible em-
14 ployee’s wages.

15 “(2) ADDITIONAL PREMIUMS.—If the amount
16 withheld under paragraph (1) is not sufficient to
17 cover the entire cost of the premiums, the eligible
18 employee shall be responsible for paying directly to
19 the qualified small employer purchasing group the
20 difference between the amount of such premiums
21 and the amount withheld.

1 **“SEC. 2707G. ENROLLING ELIGIBLE EMPLOYEES, ELIGIBLE**
 2 **INDIVIDUALS, AND CERTAIN UNINSURED IN-**
 3 **DIVIDUALS IN QUALIFIED GROUP HEALTH**
 4 **PLANS.**

5 “(a) IN GENERAL.—Each qualified small employer
 6 purchasing group shall offer—

7 “(1) eligible employees,

8 “(2) eligible individuals, and

9 “(3) certain uninsured individuals,

10 the opportunity to enroll in any qualified group health
 11 plan which has an agreement with the qualified small em-
 12 ployer purchasing group for the community rating area
 13 in which such employees and individuals reside.

14 “(b) UNINSURED INDIVIDUALS.—For purposes of
 15 this section, an individual is described in subsection (a)(3)
 16 if such individual is an uninsured individual who is not
 17 an eligible employee of a small employer that is a member
 18 of a qualified small employer purchasing group or a de-
 19 pendent of such individual.

20 **“SEC. 2707H. RECEIPT OF PREMIUMS.**

21 “(a) ENROLLMENT CHARGE.—The amount charged
 22 by a qualified small employer purchasing group for cov-
 23 erage under a qualified group health plan shall be equal
 24 to the sum of—

25 “(1) the premium rate offered by such health
 26 plan;

1 “(2) the administrative charge for such health
2 plan; and

3 “(3) the purchasing group administrative
4 charge for enrollment of eligible employees, eligible
5 individuals and certain uninsured individuals
6 through the group.

7 “(b) DISCLOSURE OF PREMIUM RATES AND ADMIN-
8 ISTRATIVE CHARGES.—Each qualified small employer
9 purchasing group shall, prior to the time of enrollment,
10 disclose to enrollees and other interested parties the pre-
11 mium rate for a qualified group health plan, the adminis-
12 trative charge for such plan, and the administrative charge
13 of the group, separately.

14 **“SEC. 2707I. MARKETING ACTIVITIES.**

15 “Each qualified small employer purchasing group
16 shall market qualified group health plans to members
17 through the entire community rating area served by the
18 purchasing group.

19 **“SEC. 2707J. GRANTS TO STATES AND QUALIFIED SMALL**
20 **EMPLOYER PURCHASING GROUPS.**

21 “(a) IN GENERAL.—The Secretary shall award
22 grants to States and small employer purchasing groups
23 to assist such States and groups in planning, developing,
24 and operating qualified small employer purchasing groups.

1 “(b) APPLICATION REQUIREMENTS.—To be eligible
2 to receive a grant under this section, a State or small em-
3 ployer purchasing group shall prepare and submit to the
4 Secretary an application in such form, at such time, and
5 containing such information, certifications, and assur-
6 ances as the Secretary shall reasonably require.

7 “(c) USE OF FUNDS.—Amounts awarded under this
8 section may be used to finance the costs associated with
9 planning, developing, and operating a qualified small em-
10 ployer purchasing group. Such costs may include the costs
11 associated with—

12 “(1) engaging in education and outreach efforts
13 to inform small employers, insurers, and the public
14 about the small employer purchasing group;

15 “(2) soliciting bids and negotiating with insur-
16 ers to make available group health plans;

17 “(3) preparing the documentation required to
18 receive certification by the Secretary as a qualified
19 small employer purchasing group; and

20 “(4) such other activities determined appro-
21 priate by the Secretary.

22 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
23 are authorized to be appropriated for awarding grants
24 under this section such sums as may be necessary.

1 **“SEC. 2707K. QUALIFIED SMALL EMPLOYER PURCHASING**
 2 **GROUPS ESTABLISHED BY A STATE.**

3 “A State may establish a system in all or part of the
 4 State under which qualified small employer purchasing
 5 groups are the sole mechanism through which health care
 6 coverage for the eligible employees of small employers shall
 7 be purchased or provided.

8 **“SEC. 2707L. EFFECTIVE DATES.**

9 “(a) IN GENERAL.—Except as provided in this chap-
 10 ter, the provisions of this chapter are effective on the date
 11 of the enactment of this chapter.

12 “(b) EXCEPTION.—The provisions of section
 13 2707C(b) shall apply to contracts which are issued, or re-
 14 newed, after the date which is 18 months after the date
 15 of the enactment of this chapter.

16 **“Subchapter B—Required Coverage Options for Eli-**
 17 **gible Employees and Dependents of Small Em-**
 18 **ployers**

19 **“SEC. 2708. REQUIRING SMALL EMPLOYERS TO OFFER COV-**
 20 **ERAGE FOR ELIGIBLE INDIVIDUALS.**

21 “(a) REQUIREMENT TO OFFER.—Each small em-
 22 ployer shall make available with respect to each eligible
 23 employee a group health plan under which—

24 “(1) coverage of each eligible individual with re-
 25 spect to such an eligible employee may be elected on
 26 an annual basis for each plan year;

1 “(2) coverage is provided for at least the stand-
2 ard coverage specified in section 2707A(b); and

3 “(3) each eligible employee electing such cov-
4 erage may elect to have any premiums owed by the
5 employee collected through payroll deduction.

6 “(b) NO EMPLOYER CONTRIBUTION REQUIRED.—An
7 employer is not required under subsection (a) to make any
8 contribution to the cost of coverage under a group health
9 plan described in such subsection.

10 “(c) SPECIAL RULES.—

11 “(1) EXCLUSION OF NEW EMPLOYERS AND
12 CERTAIN VERY SMALL EMPLOYERS.—Subsection (a)
13 shall not apply to any small employer for any plan
14 year if, as of the beginning of such plan year—

15 “(A) such employer (including any prede-
16 cessor thereof) has been an employer for less
17 than 2 years;

18 “(B) such employer has no more than 2 el-
19 igible employees; or

20 “(C) no more than 2 eligible employees are
21 not covered under any group health plan.

22 “(2) EXCLUSION OF FAMILY MEMBERS.—Under
23 such procedures as the Secretary may prescribe, any
24 relative of a small employer may be, at the election
25 of the employer, excluded from consideration as an

1 eligible employee for purposes of applying the re-
 2 quirements of subsection (a). In the case of a small
 3 employer that is not an individual, an employee who
 4 is a relative of a key employee (as defined in section
 5 416(i)(1) of the Internal Revenue Code of 1986) of
 6 the employer may, at the election of the key em-
 7 ployee, be considered a relative excludable under this
 8 paragraph.

9 “(3) OPTIONAL APPLICATION OF WAITING PE-
 10 RIOD.—A group health plan and a health insurance
 11 issuer offering group health insurance coverage shall
 12 not be treated as failing to meet the requirements of
 13 subsection (a) solely because a period of service by
 14 an eligible employee of not more than 60 days is re-
 15 quired under the plan for coverage under the plan
 16 of eligible individuals with respect to such employee.

17 “(d) CONSTRUCTION.—Nothing in this section shall
 18 be construed as limiting the group health plans, or types
 19 of coverage under such a plan, that an employer may offer
 20 to an employee.

21 **“SEC. 2708A. COMPLIANCE WITH APPLICABLE REQUIRE-**
 22 **MENTS THROUGH MULTIPLE EMPLOYER**
 23 **HEALTH ARRANGEMENTS.**

24 “(a) IN GENERAL.—In any case in which an eligible
 25 employee is, for any plan year, a participant in a group

1 health plan which is a multiemployer plan, the require-
 2 ments of section 2722(a) shall be deemed to be met with
 3 respect to such employee for such plan year if the em-
 4 ployer requirements of subsection (b) are met with respect
 5 to the eligible employee, irrespective of whether, or to what
 6 extent, the employer makes employer contributions on be-
 7 half of the eligible employee.

8 “(b) EMPLOYER REQUIREMENTS.—The employer re-
 9 quirements of this subsection are met under a group
 10 health plan with respect to an eligible employee if—

11 “(1) the employee is eligible under the plan to
 12 elect coverage on an annual basis and is provided a
 13 reasonable opportunity to make the election in such
 14 form and manner and at such times as are provided
 15 by the plan;

16 “(2) coverage is provided for at least the stand-
 17 ard coverage specified in section 2707A(b);

18 “(3) the employer facilitates collection of any
 19 employee contributions under the plan and permits
 20 the employee to elect to have employee contributions
 21 under the plan collected through payroll deduction;
 22 and

23 “(4) in the case of a plan to which subchapter
 24 A does not otherwise apply, the employer provides to
 25 the employee a summary plan description described

1 in section 102(a)(1) of the Employee Retirement In-
 2 come Security Act of 1974 in the form and manner
 3 and at such times as are required under such sub-
 4 chapter A with respect to employee welfare benefit
 5 plans.

6 **“Subchapter C—Required Coverage Options for**
 7 **Individuals Insured Through Association Plans**

8 **“SEC. 2709. TREATMENT OF QUALIFIED ASSOCIATION**
 9 **PLANS.**

10 “(a) GENERAL RULE.—For purposes of this chapter,
 11 in the case of a qualified association plan—

12 “(1) except as otherwise provided in this sub-
 13 chapter, the plan shall meet all applicable require-
 14 ments of chapter 1 and chapter 2 for group health
 15 plans offered to and by small employers;

16 “(2) if such plan is certified as meeting such
 17 requirements and the requirements of this sub-
 18 chapter, such plan shall be treated as a plan estab-
 19 lished and maintained by a small employer, and indi-
 20 viduals enrolled in such plan shall be treated as eli-
 21 gible employees; and

22 “(3) any individual who is a member of the as-
 23 sociation not enrolling in the plan shall not be treat-
 24 ed as an eligible employee solely by reason of mem-
 25 bership in such association.

1 “(b) ELECTION TO BE TREATED AS PURCHASING
2 COOPERATIVE.—Subsection (a) shall not apply to a quali-
3 fied association plan if—

4 “(1) the health insurance issuer makes an irrev-
5 ovable election to be treated as a qualified small em-
6 ployer purchasing group for purposes of section
7 2707D; and

8 “(2) such sponsor meets all requirements of
9 this chapter applicable to a purchasing cooperative.

10 **“SEC. 2709A. QUALIFIED ASSOCIATION PLAN DEFINED.**

11 “(a) GENERAL RULE.—For purposes of this chapter,
12 a plan is a qualified association plan if the plan is a mul-
13 tiple employer welfare arrangement or similar
14 arrangement—

15 “(1) which is maintained by a qualified associa-
16 tion;

17 “(2) which has at least 500 participants in the
18 United States;

19 “(3) under which the benefits provided consist
20 solely of medical care (as defined in section 213(d)
21 of the Internal Revenue Code of 1986);

22 “(4) which may not condition participation in
23 the plan, or terminate coverage under the plan, on
24 the basis of the health status or health claims expe-

1 rience of any employee or member or dependent of
2 either;

3 “(5) which provides for bonding, in accordance
4 with regulations providing rules similar to the rules
5 under section 412, of all persons operating or ad-
6 ministering the plan or involved in the financial af-
7 fairs of the plan; and

8 “(6) which notifies each participant or provider
9 that it is certified as meeting the requirements of
10 this chapter applicable to it.

11 “(b) SELF-INSURED PLANS.—In the case of a plan
12 which is not fully insured (within the meaning of section
13 514(b)(6)(D)), the plan shall be treated as a qualified as-
14 sociation plan only if—

15 “(1) the plan meets minimum financial solvency
16 and cash reserve requirements for claims which are
17 established by the Secretary and which shall be in
18 lieu of any other such requirements under this chap-
19 ter;

20 “(2) the plan provides an annual funding report
21 (certified by an independent actuary) and annual fi-
22 nancial statements to the Secretary and other inter-
23 ested parties; and

1 “(3) the plan appoints a plan sponsor who is
2 responsible for operating the plan and ensuring com-
3 pliance with applicable Federal and State laws.

4 “(c) CERTIFICATION.—

5 “(1) IN GENERAL.—A plan shall not be treated
6 as a qualified association plan for any period unless
7 there is in effect a certification by the Secretary that
8 the plan meets the requirements of this subchapter.
9 For purposes of this chapter, the Secretary shall be
10 the appropriate certifying authority with respect to
11 the plan.

12 “(2) FEE.—The Secretary shall require a
13 \$5,000 fee for the original certification under para-
14 graph (1) and may charge a reasonable annual fee
15 to cover the costs of processing and reviewing the
16 annual statements of the plan.

17 “(3) EXPEDITED PROCEDURES.—The Secretary
18 may by regulation provide for expedited registration,
19 certification, and comment procedures.

20 “(4) AGREEMENTS.—The Secretary of Labor
21 may enter into agreements with the States to carry
22 out the Secretary’s responsibilities under this sub-
23 chapter.

24 “(d) AVAILABILITY.—Notwithstanding any other
25 provision of this chapter, a qualified association plan may

1 limit coverage to individuals who are members of the
 2 qualified association establishing or maintaining the plan,
 3 an employee of such member, or a dependent of either.

4 “(e) SPECIAL RULES FOR EXISTING PLANS.—In the
 5 case of a plan in existence on January 1, 1999—

6 “(1) the requirements of subsection (a) (other
 7 than paragraphs (4), (5), and (6) thereof) shall not
 8 apply;

9 “(2) no original certification shall be required
 10 under this subchapter; and

11 “(3) no annual report or funding statement
 12 shall be required before January 1, 2001, but the
 13 plan shall file with the Secretary a description of the
 14 plan and the name of the health insurance issuer.

15 **“SEC. 2709B. DEFINITIONS AND SPECIAL RULES.**

16 “(a) QUALIFIED ASSOCIATION.—For purposes of this
 17 subchapter, the term ‘qualified association’ means any or-
 18 ganization which—

19 “(1) is organized and maintained in good faith
 20 by a trade association, an industry association, a
 21 professional association, a chamber of commerce, a
 22 religious organization, a public entity association, or
 23 other business association serving a common or simi-
 24 lar industry;

1 “(2) is organized and maintained for substan-
2 tial purposes other than to provide a health plan;

3 “(3) has a constitution, bylaws, or other similar
4 governing document which states its purpose; and

5 “(4) receives a substantial portion of its finan-
6 cial support from its active, affiliated, or federation
7 members.

8 “(b) COORDINATION.—The term ‘qualified associa-
9 tion plan’ shall not include a plan to which subchapter
10 B applies.

11 **“SEC. 2709C. SPECIAL RULE FOR CHURCH, MULTIEM-**
12 **PLOYER, AND COOPERATIVE PLANS.**

13 “(a) GENERAL RULE.—For purposes of this chapter,
14 in the case of a group health plan to which this section
15 applies—

16 “(1) except as otherwise provided in this sub-
17 chapter, the plan shall be required to meet all appli-
18 cable requirements of subchapter A and subchapter
19 B for group health plans offered to and by small em-
20 ployers;

21 “(2) if such plan is certified as meeting such
22 requirements, such plan shall be treated as a plan
23 established and maintained by a small employer and
24 individuals enrolled in such plan shall be treated as
25 eligible employees; and

1 “(3) any individual eligible to enroll in the plan
2 who does not enroll in the plan shall not be treated
3 as an eligible employee solely by reason of being eli-
4 gible to enroll in the plan.

5 “(b) MODIFIED STANDARDS.—

6 “(1) CERTIFYING AUTHORITY.—For purposes
7 of this chapter, the Secretary shall be the appro-
8 priate certifying authority with respect to a plan to
9 which this section applies.

10 “(2) AVAILABILITY.—Rules similar to the rules
11 of subsection (e) of section 2709A shall apply to a
12 plan to which this section applies.

13 “(3) ACCESS.—An employer which, pursuant to
14 a collective bargaining agreement, offers an em-
15 ployee the opportunity to enroll in a plan described
16 in subsection (c)(2) shall not be required to make
17 any other plan available to the employee.

18 “(4) TREATMENT UNDER STATE LAWS.—A
19 church plan described in subsection (c)(1) which is
20 certified as meeting the requirements of this section
21 shall not be deemed to be a multiple employer wel-
22 fare arrangement or an insurance company or other
23 insurer, or to be engaged in the business of insur-
24 ance, for purposes of any State law purporting to
25 regulate insurance companies or insurance contracts.

1 “(c) PLANS TO WHICH SECTION APPLIES.—This sec-
 2 tion shall apply to a health plan which—

3 “(1) is a church plan (as defined in section
 4 414(e) of the Internal Revenue Code of 1986) which
 5 has at least 100 participants in the United States;

6 “(2) is a multiemployer plan which is main-
 7 tained by a health plan sponsor described in section
 8 3(16)(B)(iii) of the Employee Retirement Income
 9 Security Act of 1974 and which has at least 500
 10 participants in the United States; or

11 “(3) is a plan which is maintained by a rural
 12 electric cooperative or a rural telephone cooperative
 13 association and which has at least 500 participants
 14 in the United States.”.

15 (b) CONFORMING AMENDMENTS.—Section 2791(d)
 16 of the Public Health Service Act (42 U.S.C. 300gg–91(d))
 17 is amended by adding at the end the following:

18 “(15) ELIGIBLE EMPLOYEE.—The term ‘eligible
 19 employee’ means, with respect to an employer, an
 20 employee who normally performs on a monthly basis
 21 at least 30 hours of service per week for that em-
 22 ployer.

23 “(16) ELIGIBLE INDIVIDUAL.—The term ‘eligi-
 24 ble individual’ means, with respect to an eligible em-

1 employee, such employee, and any dependent of such
2 employee.

3 “(17) NAIC.—The term ‘NAIC’ means the Na-
4 tional Association of Insurance Commissioners.

5 “(18) QUALIFIED GROUP HEALTH PLAN.—The
6 term ‘qualified group health plan’ shall have the
7 meaning given the term in section 2707.”.

8 **SEC. 303. AMENDMENT TO THE PUBLIC HEALTH SERVICE**
9 **ACT RELATING TO THE INDIVIDUAL MARKET.**

10 Subpart 3 of part B of title XXVII of the Public
11 Health Service Act (42 U.S.C. 300gg-51 et seq.), as
12 amended by the Omnibus Consolidated and Emergency
13 Supplemental Appropriations Act, 1999 (Public Law 105-
14 277), is amended by adding at the end the following:

15 **“SEC. 2753. APPLICABILITY OF GENERAL INSURANCE MAR-**
16 **KET REFORMS.**

17 “The provisions of chapter 2 of subpart 2 of part A
18 shall apply to health insurance coverage offered by a
19 health insurance issuer in the individual market in the
20 same manner as they apply to health insurance coverage
21 offered by a health insurance issuer in connection with a
22 group health plan in the small or large group market.”.

23 **SEC. 304. EFFECTIVE DATE.**

24 The amendments made by this subtitle shall apply
25 with respect to health insurance coverage offered, sold,

1 issued, renewed, in effect, or operated on or after January
2 1, 2000.

3 **Subtitle B—Tax Provisions**

4 **SEC. 311. ENFORCEMENT WITH RESPECT TO HEALTH IN-** 5 **SURANCE ISSUERS.**

6 (a) IN GENERAL.—Chapter 43 of the Internal Reve-
7 nue Code of 1986 (relating to qualified pension, etc.,
8 plans) is amended by adding at the end the following:

9 **“SEC. 4980F. FAILURE OF INSURER TO COMPLY WITH CER-** 10 **TAIN STANDARDS FOR HEALTH INSURANCE** 11 **COVERAGE.**

12 “(a) IMPOSITION OF TAX.—

13 “(1) IN GENERAL.—There is hereby imposed a
14 tax on the failure of a health insurance issuer to
15 comply with the requirements applicable to such
16 issuer under—

17 “(A) chapter 2 of subpart 2 of part A of
18 title XXVII of the Public Health Service Act;

19 “(B) section 2753 of the Public Health
20 Service Act; and

21 “(C) subpart C of part 7 of subtitle B of
22 title I of the Employee Retirement Income Se-
23 curity Act of 1974.

24 “(2) EXCEPTION.—Paragraph (1) shall not
25 apply to a failure by a health insurance issuer in a

1 State if the Secretary of Health and Human Serv-
 2 ices determines that the State has in effect a regu-
 3 latory enforcement mechanism that provides ade-
 4 quate sanctions with respect to such a failure by
 5 such an issuer.

6 “(b) AMOUNT OF TAX.—

7 “(1) IN GENERAL.—Subject to paragraph (2),
 8 the amount of the tax imposed by subsection (a)
 9 shall be \$100 for each day during which such failure
 10 persists for each person to which such failure re-
 11 lates. A rule similar to the rule of section
 12 4980D(b)(3) shall apply for purposes of this section.

13 “(2) LIMITATION.—The amount of the tax im-
 14 posed by subsection (a) for a health insurance issuer
 15 with respect to health insurance coverage shall not
 16 exceed 25 percent of the amounts received under the
 17 coverage for coverage during the period such failure
 18 persists.

19 “(c) LIABILITY FOR TAX.—The tax imposed by this
 20 section shall be paid by the health insurance issuer.

21 “(d) LIMITATIONS ON AMOUNT OF TAX.—

22 “(1) TAX NOT TO APPLY TO FAILURES COR-
 23 RECTED WITHIN 30 DAYS.—No tax shall be imposed
 24 by subsection (a) on any failure if—

1 “(A) such failure was due to reasonable
2 cause and not to willful neglect, and

3 “(B) such failure is corrected during the
4 30-day period (or such period as the Secretary
5 may determine appropriate) beginning on the
6 first date the health insurance issuer knows, or
7 exercising reasonable diligence could have
8 known, that such failure existed.

9 “(2) WAIVER BY SECRETARY.—In the case of a
10 failure which is due to reasonable cause and not to
11 willful neglect, the Secretary may waive part or all
12 of the tax imposed by subsection (a) to the extent
13 that the payment of such tax would be excessive rel-
14 ative to the failure involved.

15 “(e) DEFINITIONS.—For purposes of this section, the
16 terms ‘health insurance coverage’ and ‘health insurance
17 issuer’ have the meanings given such terms in section
18 2791 of the Public Health Service Act and section 733
19 of the Employee Retirement Income Security Act of
20 1974.”.

21 (b) CONFORMING AMENDMENT.—The table of sec-
22 tions for such chapter 43 is amended by adding at the
23 end the following new item:

 “Sec. 4980F. Failure of insurer to comply with certain standards
 for health insurance coverage.”.

1 **SEC. 312. ENFORCEMENT WITH RESPECT TO SMALL EM-**
 2 **PLOYERS.**

3 (a) IN GENERAL.—Chapter 47 of the Internal Reve-
 4 nue Code of 1986 (relating to excise taxes on certain
 5 group health plans) is amended by inserting after section
 6 5000 the following new section:

7 **“SEC. 5000A. SMALL EMPLOYER REQUIREMENTS.**

8 “(a) GENERAL RULE.—There is hereby imposed a
 9 tax on the failure of any small employer to comply with
 10 the requirements applicable to such employer under—

11 “(1) subchapter C of chapter 2 of subpart 2 of
 12 part A of title XXVII of the Public Health Service
 13 Act;

14 “(2) section 2753 of the Public Health Service
 15 Act; and

16 “(3) chapter 2 of subpart C of part 7 of sub-
 17 title B of title I of the Employee Retirement Income
 18 Security Act of 1974.

19 “(b) AMOUNT OF TAX.—The amount of tax imposed
 20 by subsection (a) shall be equal to \$100 for each day for
 21 each individual for which such a failure occurs.

22 “(c) LIMITATION ON TAX.—

23 “(1) TAX NOT TO APPLY WHERE FAILURES
 24 CORRECTED WITHIN 30 DAYS.—No tax shall be im-
 25 posed by subsection (a) with respect to any failure
 26 if—

1 “(A) such failure was due to reasonable
2 cause and not to willful neglect, and

3 “(B) such failure is corrected during the
4 30-day period (or such period as the Secretary
5 may determine appropriate) beginning on the
6 1st date any of the individuals on whom the tax
7 is imposed knew, or exercising reasonable dili-
8 gence would have known, that such failure ex-
9 isted.

10 “(2) WAIVER BY SECRETARY.—In the case of a
11 failure which is due to reasonable cause and not to
12 willful neglect, the Secretary may waive part or all
13 of the tax imposed by subsection (a) to the extent
14 that the payment of such tax would be excessive rel-
15 ative to the failure involved.”.

16 (b) CONFORMING AMENDMENT.—The table of sec-
17 tions for such chapter 47 is amended by adding at the
18 end the following new item:

 “Sec. 5000A. Small employer requirements.”.

19 **SEC. 313. ENFORCEMENT BY EXCISE TAX ON QUALIFIED AS-**
20 **SOCIATIONS.**

21 (a) IN GENERAL.—Chapter 43 of the Internal Reve-
22 nue Code of 1986 (relating to qualified pension, etc.,
23 plans), as amended by section 311, is amended by adding
24 at the end the following new section:

1 **“SEC. 4980G. FAILURE OF QUALIFIED ASSOCIATIONS, ETC.,**
 2 **TO COMPLY WITH CERTAIN STANDARDS FOR**
 3 **HEALTH INSURANCE COVERAGE.**

4 “(a) IMPOSITION OF TAX.—

5 “(1) IN GENERAL.—There is hereby imposed a
 6 tax on the failure of a qualified association (as de-
 7 fined in section 2709A of the Public Health Service
 8 Act and section 723A of the Employee Retirement
 9 Income Security Act of 1974), church plan (as de-
 10 fined in section 414(e)), multiemployer plan, or plan
 11 maintained by a rural electric cooperative or a rural
 12 telephone cooperative association (within the mean-
 13 ing of section 3(40) of the Employee Retirement In-
 14 come Security Act of 1974) to comply with the re-
 15 quirements applicable to such association or plans
 16 under—

17 “(A) subchapter C of chapter 2 of subpart
 18 2 of part A of title XXVII of the Public Health
 19 Service Act;

20 “(B) section 2753 of the Public Health
 21 Service Act; and

22 “(C) subchapters A and B of chapter 3 of
 23 subpart C of part 7 of the Employee Retire-
 24 ment Income Security Act of 1974.

25 “(2) EXCEPTION.—Paragraph (1) shall not
 26 apply to a failure by a qualified association, church

1 plan, multiemployer plan, or plan maintained by a
 2 rural electric cooperative or a rural telephone coop-
 3 erative association in a State if the Secretary of
 4 Health and Human Services determines that the
 5 State has in effect a regulatory enforcement mecha-
 6 nism that provides adequate sanctions with respect
 7 to such a failure by such a qualified association or
 8 plan.

9 “(b) AMOUNT OF TAX.—The amount of the tax im-
 10 posed by subsection (a) shall be \$100 for each day during
 11 which such failure persists for each person to which such
 12 failure relates. A rule similar to the rule of section
 13 4980D(b)(3) shall apply for purposes of this section.

14 “(c) LIABILITY FOR TAX.—The tax imposed by this
 15 section shall be paid by the qualified association or plan.

16 “(d) LIMITATIONS ON AMOUNT OF TAX.—

17 “(1) TAX NOT TO APPLY TO FAILURES COR-
 18 RECTED WITHIN 30 DAYS.—No tax shall be imposed
 19 by subsection (a) on any failure if—

20 “(A) such failure was due to reasonable
 21 cause and not to willful neglect, and

22 “(B) such failure is corrected during the
 23 30-day period (or such period as the Secretary
 24 may determine appropriate) beginning on the
 25 first date the qualified association, church plan,

1 multiemployer plan, or plan maintained by a
 2 rural electric cooperative or a rural telephone
 3 cooperative association knows, or exercising rea-
 4 sonable diligence could have known, that such
 5 failure existed.

6 “(2) WAIVER BY SECRETARY.—In the case of a
 7 failure which is due to reasonable cause and not to
 8 willful neglect, the Secretary may waive part or all
 9 of the tax imposed by subsection (a) to the extent
 10 that the payment of such tax would be excessive rel-
 11 ative to the failure involved.”.

12 (b) CONFORMING AMENDMENT.—The table of sec-
 13 tions for such chapter 43, as amended by section 311, is
 14 amended by adding at the end the following new item:

“Sec. 4980G. Failure of qualified associations, etc., to comply
 with certain standards for health insurance plans.”.

15 **SEC. 314. DEDUCTION FOR HEALTH INSURANCE COSTS OF**
 16 **SELF-EMPLOYED INDIVIDUALS.**

17 (a) FULL DEDUCTION IN 2001.—The table contained
 18 in section 162(l)(1)(B) of the Internal Revenue Code of
 19 1986 (relating to special rules for health insurance costs
 20 of self-employed individuals) is amended—

21 (1) by striking “2000 and 2001” and all that
 22 follows; and

23 (2) by adding at the end the following:

“2000	50
“2001 and thereafter	100.”.

1 (b) EFFECTIVE DATE.—The amendments made by
 2 this section shall apply to taxable years beginning after
 3 December 31, 1999.

4 **SEC. 315. AMENDMENTS TO COBRA.**

5 (a) AMENDMENTS TO INTERNAL REVENUE CODE OF
 6 1986.—

7 (1) LOWER COST COVERAGE OPTIONS.—Sub-
 8 paragraph (A) of section 4980B(f)(2) of the Internal
 9 Revenue Code of 1986 (relating to continuation cov-
 10 erage requirements of group health plans) is amend-
 11 ed to read as follows:

12 “(A) TYPE OF BENEFIT COVERAGE.—The
 13 coverage must consist of coverage which, as of
 14 the time the coverage is being provided—

15 “(i) is identical to the coverage pro-
 16 vided under the plan to similarly situated
 17 beneficiaries under the plan with respect to
 18 whom a qualifying event has not occurred,

19 “(ii) is so identical, except such cov-
 20 erage is offered with an annual \$1,000 de-
 21 ductible, and

22 “(iii) is so identical, except such cov-
 23 erage is offered with an annual \$3,000 de-
 24 ductible.

1 If coverage under the plan is modified for any
 2 group of similarly situated beneficiaries, the
 3 coverage shall also be modified in the same
 4 manner for all individuals who are qualified
 5 beneficiaries under the plan pursuant to this
 6 subsection in connection with such group.”.

7 (2) TERMINATION OF COBRA COVERAGE AFTER
 8 ELIGIBLE FOR EMPLOYER-BASED COVERAGE FOR 90
 9 DAYS.—Clause (iv) of section 4980B(f)(2)(B) of the
 10 Internal Revenue Code of 1986 (relating to period of
 11 coverage) is amended—

12 (A) by striking “or” at the end of sub-
 13 clause (I),

14 (B) by redesignating subclause (II) as sub-
 15 clause (III), and

16 (C) by inserting after subclause (I) the fol-
 17 lowing:

18 “(II) eligible for such employer-
 19 based coverage for more than 90 days,
 20 or”.

21 (3) REDUCTION OF PERIOD OF COVERAGE.—
 22 Clause (i) of section 4980B(f)(2)(B) of the Internal
 23 Revenue Code of 1986 (relating to period of cov-
 24 erage) is amended by striking “18 months” each
 25 place it appears and inserting “24 months”.

(4) CONTINUATION COVERAGE FOR DEPENDENT CHILD.—Clause (i) of section 4980B(f)(2)(B) of the Internal Revenue Code of 1986 is amended by adding at the end the following:

“(VI) SPECIAL RULE FOR DEPENDENT CHILD.—In the case of a qualifying event described in paragraph (3)(E), the date that is 36 months after the date on which the dependent child of the covered employee ceases to be a dependent child under the plan.”.

(b) AMENDMENTS TO EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) LOWER COST COVERAGE OPTIONS.—Paragraph (1) of section 602 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1162(1)) (relating to continuation coverage requirements of group health plans) is amended to read as follows:

“(1) TYPE OF BENEFIT COVERAGE.—The coverage must consist of coverage which, as of the time the coverage is being provided—

“(A) is identical to the coverage provided under the plan to similarly situated bene-

1 ficiaries under the plan with respect to whom a
2 qualifying event has not occurred,

3 “(B) is so identical, except such coverage
4 is offered with an annual \$1,000 deductible,
5 and

6 “(C) is so identical, except such coverage is
7 offered with an annual \$3,000 deductible.

8 If coverage under the plan is modified for any group
9 of similarly situated beneficiaries, the coverage shall
10 also be modified in the same manner for all individ-
11 uals who are qualified beneficiaries under the plan
12 pursuant to this subsection in connection with such
13 group.”.

14 (2) TERMINATION OF COBRA COVERAGE AFTER
15 ELIGIBLE FOR EMPLOYER-BASED COVERAGE FOR 90
16 DAYS.—Subparagraph (D) of section 602(2) of the
17 Employee Retirement Income Security Act of 1974
18 (29 U.S.C. 1162(2)(D)) (relating to period of cov-
19 erage) is amended—

20 (A) by striking “or” at the end of clause

21 (i),

22 (B) by redesignating clause (ii) as clause

23 (iii), and

24 (C) by inserting after clause (i) the follow-

25 ing:

1 “(ii) eligible for such employer-based
2 coverage for more than 90 days, or”.

3 (3) REDUCTION OF PERIOD OF COVERAGE.—
4 Subparagraph (A) of section 602(2) of the Employee
5 Retirement Income Security Act of 1974 (29 U.S.C.
6 1162(2)(A)) (relating to period of coverage) is
7 amended by striking “18 months” each place it ap-
8 pears and inserting “24 months”.

9 (4) CONTINUATION COVERAGE FOR DEPENDENT
10 CHILD.—Subparagraph (A) of section 602(2) of the
11 Employee Retirement Income Security Act of 1974
12 (29 U.S.C. 1162(2)(A)) is amended by adding at the
13 end the following:

14 “(vi) SPECIAL RULE FOR DEPENDENT
15 CHILD.—In the case of a qualifying event
16 described in section 603(5), the date that
17 is 36 months after the date on which the
18 dependent child of the covered employee
19 ceases to be a dependent child under the
20 plan.”.

21 (c) AMENDMENTS TO PUBLIC HEALTH SERVICE
22 ACT.—

23 (1) LOWER COST COVERAGE OPTIONS.—Para-
24 graph (1) of section 2202 of the Public Health Serv-
25 ice Act (42 U.S.C. 300bb-2(1)) (relating to continu-

1 ation coverage requirements of group health plans)
 2 is amended to read as follows:

3 “(1) TYPE OF BENEFIT COVERAGE.—The cov-
 4 erage must consist of coverage which, as of the time
 5 the coverage is being provided—

6 “(A) is identical to the coverage provided
 7 under the plan to similarly situated bene-
 8 ficiaries under the plan with respect to whom a
 9 qualifying event has not occurred,

10 “(B) is so identical, except such coverage
 11 is offered with an annual \$1,000 deductible,
 12 and

13 “(C) is so identical, except such coverage is
 14 offered with an annual \$3,000 deductible.

15 If coverage under the plan is modified for any group
 16 of similarly situated beneficiaries, the coverage shall
 17 also be modified in the same manner for all individ-
 18 uals who are qualified beneficiaries under the plan
 19 pursuant to this subsection in connection with such
 20 group.”.

21 (2) TERMINATION OF COBRA COVERAGE AFTER
 22 ELIGIBLE FOR EMPLOYER-BASED COVERAGE FOR 90
 23 DAYS.—Subparagraph (D) of section 2202(2) of the
 24 Public Health Service Act (42 U.S.C. 300bb-

1 2(2)(D)) (relating to period of coverage) is
2 amended—

3 (A) by striking “or” at the end of clause

4 (i),

5 (B) by redesignating clause (ii) as clause

6 (iii), and

7 (C) by inserting after clause (i) the follow-
8 ing:

9 “(ii) eligible for such employer-based
10 coverage for more than 90 days, or”.

11 (3) REDUCTION OF PERIOD OF COVERAGE.—

12 Subparagraph (A) of section 2202(2) of the Public
13 Health Service Act (42 U.S.C. 300bb-2(2)(A)) (re-
14 lating to period of coverage) is amended by striking
15 “18 months” each place it appears and inserting
16 “24 months”.

17 (4) CONTINUATION COVERAGE FOR DEPENDENT

18 CHILD.—Subparagraph (A) of section 2202(2) of the

19 Public Health Service Act (42 U.S.C. 300bb-

20 2(2)(A)) is amended by adding at the end the follow-

21 ing:

22 “(vi) SPECIAL RULE FOR DEPENDENT

23 CHILD.—In the case of a qualifying event

24 described in section 2203(5), the date that

25 is 36 months after the date on which the

1 dependent child of the covered employee
 2 ceases to be a dependent child under the
 3 plan.”.

4 (d) EFFECTIVE DATE.—The amendments made by
 5 this section shall apply to qualifying events occurring after
 6 the date of the enactment of this Act.

7 **TITLE IV—PRIMARY AND** 8 **PREVENTIVE CARE SERVICES**

9 **SEC. 401. IMPROVEMENT OF MEDICARE PREVENTIVE CARE** 10 **SERVICES.**

11 (a) WAIVER OF COINSURANCE FOR SCREENING MAM-
 12 MOGRAPHY.—

13 (1) IN GENERAL.—Section 1834(c)(1)(C) of the
 14 Social Security Act (42 U.S.C. 1395m(c)(1)(C)) is
 15 amended by striking “80 percent of”.

16 (2) WAIVER OF COINSURANCE IN OUTPATIENT
 17 HOSPITAL SETTINGS.—The third sentence of section
 18 1866(a)(2)(A) of the Social Security Act (42 U.S.C.
 19 1395cc(a)(2)(A)) is amended by inserting after
 20 “1861(s)(10)(A)” the following: “, with respect to
 21 screening mammography (as defined in section
 22 1861(jj)),”.

23 (b) COVERAGE OF INSULIN PUMPS.—

24 (1) INCLUSION AS ITEM OF DURABLE MEDICAL
 25 EQUIPMENT.—Section 1861(n) of the Social Secu-

1 rity Act (42 U.S.C. 1395x(n)) is amended by insert-
 2 ing before the semicolon the following: “, and in-
 3 cludes insulin infusion pumps (as defined in sub-
 4 section (uu)) prescribed by the physician of an indi-
 5 vidual with Type I diabetes who is experiencing se-
 6 vere swings of high and low blood glucose levels and
 7 has successfully completed a training program that
 8 meets standards established by the Secretary or who
 9 has used such a pump without interruption for at
 10 least 18 months immediately before enrollment
 11 under part B”.

12 (2) DEFINITION OF INSULIN INFUSION PUMP.—
 13 Section 1861 of the Social Security Act (42 U.S.C.
 14 1395x) is amended by adding at the end the follow-
 15 ing:

16 “Insulin Infusion Pump

17 “(uu) The term ‘insulin infusion pump’ means an in-
 18 fusion pump, approved by the Federal Food and Drug Ad-
 19 ministration, that provides for the computerized delivery
 20 of insulin for individuals with diabetes in lieu of multiple
 21 daily manual insulin injections.”.

22 (3) PAYMENT FOR SUPPLIES RELATING TO IN-
 23 FUSION PUMPS.—Section 1834(a)(2)(A) of the So-
 24 cial Security Act (42 U.S.C. 1395m(a)(2)(A)) is
 25 amended—

1 (A) in clause (ii), by striking “or” at the
2 end;

3 (B) in clause (iii), by inserting “or” at the
4 end; and

5 (C) by inserting after clause (iii) the fol-
6 lowing:

7 “(iv) which is an accessory used in
8 conjunction with an insulin infusion pump
9 (as defined in section 1861(uu)),”.

10 (c) ANNUAL SCREENING PAP SMEAR AND PELVIC
11 EXAMS.—

12 (1) IN GENERAL.—Section 1861(nn) of the So-
13 cial Security Act (42 U.S.C. 1395x(nn)) is amended
14 to read as follows:

15 “Screening Pap Smear; Screening Pelvic Exam

16 “(nn)(1) The term ‘screening pap smear’ means a di-
17 agnostic laboratory test consisting of a routine exfoliative
18 cytology test (Papanicolaou test) provided to a woman for
19 the purpose of early detection of cervical or vaginal cancer
20 and includes a physician’s interpretation of the results of
21 the test, if the individual involved has not had such a test
22 during the preceding year.

23 “(2) The term ‘screening pelvic exam’ means a pelvic
24 examination provided to a woman if the woman involved
25 has not had such an examination during the preceding

1 year, and includes a clinical breast examination, relevant
 2 history-taking, medical decision-making, and patient coun-
 3 seling.”.

4 (2) WAIVER OF COINSURANCE FOR PELVIC
 5 EXAMS.—Section 1833(a)(1) of the Social Security
 6 Act (42 U.S.C. 1395l(a)(1)) is amended—

7 (A) by striking “and (S)” and inserting
 8 “(S)”; and

9 (B) by striking the semicolon at the end
 10 and inserting the following: “, and (T) with re-
 11 spect to services described in section
 12 1861(n)(2), 100 percent of the payment basis
 13 established under section 1848;”.

14 (e) EFFECTIVE DATE.—The amendments made by
 15 this section shall apply to items and services furnished on
 16 or after the date of enactment of this Act.

17 **SEC. 402. AUTHORIZATION OF APPROPRIATIONS FOR**
 18 **HEALTHY START PROGRAM.**

19 (a) AUTHORIZATION OF APPROPRIATIONS.—To en-
 20 able the Secretary of Health and Human Services to carry
 21 out the healthy start program established under the au-
 22 thority of section 301 of the Public Health Service Act
 23 (42 U.S.C. 241), there are authorized to be appropriated
 24 \$115,000,000 for fiscal year 2000, \$150,000,000 for fis-
 25 cal year 2001, \$250,000,000 for fiscal year 2002, and

1 \$300,000,000 for each of the fiscal years 2003 through
2 2005.

3 (b) MODEL PROJECTS.—

4 (1) IN GENERAL.—Of the amount appropriated
5 under subsection (a) for a fiscal year, the Secretary
6 of Health and Human Services shall reserve
7 \$50,000,000 for such fiscal year to be distributed to
8 model projects determined to be eligible under para-
9 graph (2).

10 (2) ELIGIBILITY.—To be eligible to receive
11 funds under paragraph (1), a model project shall—

12 (A) have been one of the original 15
13 Healthy Start projects; and

14 (B) be determined by Secretary of Health
15 and Human Services to have been successful in
16 serving needy areas and reducing infant mortal-
17 ity.

18 (3) USE OF PROJECTS.—A model project that
19 receives funding under paragraph (1) shall be uti-
20 lized as a resource center to assist in the training
21 of those individuals to be involved in projects estab-
22 lished under subsection (c). It shall be the goal of
23 such projects to become self-sustaining within the
24 project area.

1 (4) PROVISION OF MATCHING FUNDS.—In pro-
2 viding assistance to a project under this subsection,
3 the Secretary of Health and Human Services shall
4 ensure that—

5 (A) with respect to fiscal year 2000, the
6 project shall make non-Federal contributions
7 (in cash or in-kind) towards the costs of such
8 project in an amount equal to not less than 20
9 percent of such costs;

10 (B) with respect to fiscal year 2001, the
11 project shall make non-Federal contributions
12 (in cash or in-kind) towards the costs of such
13 project in an amount equal to not less than 30
14 percent of such costs;

15 (C) with respect to fiscal year 2002, the
16 project shall make non-Federal contributions
17 (in cash or in-kind) towards the costs of such
18 project in an amount equal to not less than 40
19 percent of such costs; and

20 (D) with respect to each of the fiscal years
21 2003 through 2005, the project shall make non-
22 Federal contributions (in cash or in-kind) to-
23 wards the costs of such project in an amount
24 equal to not less than 50 percent of such costs
25 for each such fiscal year.

1 (c) NEW PROJECTS.—Of the amount appropriated
 2 under subsection (a) for a fiscal year, the Secretary of
 3 Health and Human Services shall allocate amounts re-
 4 maining after the reservation under subsection (b) for
 5 such fiscal year among new demonstration projects and
 6 existing special projects that have proven to be successful
 7 as determined by the Secretary of Health and Human
 8 Services. Such projects shall be community-based and
 9 shall attempt to replicate healthy start model projects that
 10 have been determined by the Secretary of Health and
 11 Human Services to be successful.

12 **SEC. 403. REAUTHORIZATION OF CERTAIN PROGRAMS PRO-**
 13 **VIDING PRIMARY AND PREVENTIVE CARE.**

14 (a) TUBERCULOSIS PREVENTION GRANTS.—Section
 15 317(j)(1) of the Public Health Service Act (42 U.S.C.
 16 247b(j)(1)) is amended by striking “2002” and inserting
 17 “2003”.

18 (b) SEXUALLY TRANSMITTED DISEASES.—Section
 19 318(e)(1) of the Public Health Service Act (42 U.S.C.
 20 247c(e)(1)) is amended—

- 21 (1) by striking “and such sums” and inserting
 22 “such sums”;
 23 (2) by striking “1998” and inserting “1999”;
 24 and

1 (3) by inserting before the period the following:

2 “, \$130,000,000 for each of the fiscal years 2000
3 and 2001, and such sums as may be necessary for
4 each of the fiscal years 2002 through 2004”.

5 (c) FAMILY PLANNING PROJECT GRANTS.—Section
6 1001(d) of the Public Health Service Act (42 U.S.C.
7 300(d)) is amended—

8 (1) by striking “and \$158,400,000” and insert-
9 ing “\$158,400,000”; and

10 (2) by inserting before the period the following:
11 “; \$430,000,000 for fiscal year 2000; and such sums
12 as may be necessary for each of the fiscal years
13 2001 through 2003”.

14 (d) BREAST AND CERVICAL CANCER PREVENTION.—
15 Section 1510(a) of the Public Health Service Act (42
16 U.S.C. 300n–5(a)) is amended—

17 (1) by striking “and such sums” and inserting
18 “such sums”; and

19 (2) by inserting before the period the following:
20 “, \$185,000,000 for fiscal year 2000, and such sums
21 as may be necessary for each of the fiscal years
22 2001 through 2003”.

23 (e) PREVENTIVE HEALTH AND HEALTH SERVICES
24 BLOCK GRANT.—Section 1901(a) of the Public Health

1 Service Act (42 U.S.C. 300w(a)) is amended by striking
2 “\$205,000,000” and inserting “\$235,000,000”.

3 (f) MATERNAL AND CHILD HEALTH SERVICES
4 BLOCK GRANT.—Section 501(a) of the Social Security
5 Act (42 U.S.C. 701(a)) is amended by striking
6 “\$705,000,000 for fiscal year 1994 and each fiscal year
7 thereafter” and inserting “\$705,000,000 for fiscal years
8 1994 through 1999, \$800,000,000 for fiscal year 2000,
9 and such sums as may be necessary for each of the fiscal
10 years 2001 through 2003”.

11 **SEC. 404. COMPREHENSIVE SCHOOL HEALTH EDUCATION**
12 **PROGRAM.**

13 (a) PURPOSE.—It is the purpose of this section to
14 establish a comprehensive school health education and pre-
15 vention program for elementary and secondary school stu-
16 dents.

17 (b) PROGRAM AUTHORIZED.—The Secretary of Edu-
18 cation (referred to in this section as the “Secretary”),
19 through the Office of Comprehensive School Health Edu-
20 cation established in subsection (e), shall award grants to
21 States from allotments under subsection (c) to enable such
22 States to—

23 (1) award grants to local or intermediate edu-
24 cational agencies, and consortia thereof, to enable
25 such agencies or consortia to establish, operate, and

1 improve local programs of comprehensive health edu-
 2 cation and prevention, early health intervention, and
 3 health education, in elementary and secondary
 4 schools (including preschool, kindergarten, inter-
 5 mediate, and junior high schools); and

6 (2) develop training, technical assistance, and
 7 coordination activities for the programs assisted pur-
 8 suant to paragraph (1).

9 (c) RESERVATIONS AND STATE ALLOTMENTS.—

10 (1) RESERVATIONS.—From the sums appro-
 11 priated pursuant to the authority of subsection (f)
 12 for any fiscal year, the Secretary shall reserve—

13 (A) 1 percent for payments to Guam,
 14 American Samoa, the Virgin Islands, the Re-
 15 public of the Marshall Islands, the Federated
 16 States of Micronesia, the Northern Mariana Is-
 17 lands, and the Republic of Palau, to be allotted
 18 in accordance with their respective needs; and

19 (B) 1 percent for payments to the Bureau
 20 of Indian Affairs.

21 (2) STATE ALLOTMENTS.—From the remainder
 22 of the sums not reserved under paragraph (1), the
 23 Secretary shall allot to each State an amount which
 24 bears the same ratio to the amount of such remain-
 25 der as the school-age population of the State bears

1 to the school-age population of all States, except
 2 that no State shall be allotted less than an amount
 3 equal to 0.5 percent of such remainder.

4 (3) REALLOTMENT.—The Secretary may reallocate
 5 any amount of any allotment to a State to the extent
 6 that the Secretary determines that the State will not
 7 be able to obligate such amount within 2 years of
 8 allotment. Any such reallocation shall be made on
 9 the same basis as an allotment under paragraph (2).

10 (d) USE OF FUNDS.—Grant funds provided to local
 11 or intermediate educational agencies, or consortia thereof,
 12 under this section may be used to improve elementary and
 13 secondary education in the areas of—

- 14 (1) personal health and fitness;
- 15 (2) prevention of chronic diseases;
- 16 (3) prevention and control of communicable dis-
- 17 eases;
- 18 (4) nutrition;
- 19 (5) substance use and abuse;
- 20 (6) accident prevention and safety;
- 21 (7) community and environmental health;
- 22 (8) mental and emotional health;
- 23 (9) parenting and the challenges of raising chil-
- 24 dren; and

1 (10) the effective use of the health services de-
2 livery system.

3 (e) OFFICE OF COMPREHENSIVE SCHOOL HEALTH
4 EDUCATION.—The Secretary shall establish within the Of-
5 fice of the Secretary an Office of Comprehensive School
6 Health Education which shall have the following respon-
7 sibilities:

8 (1) To recommend mechanisms for the coordi-
9 nation of school health education programs con-
10 ducted by the various departments and agencies of
11 the Federal Government.

12 (2) To advise the Secretary on formulation of
13 school health education policy within the Depart-
14 ment of Education.

15 (3) To disseminate information on the benefits
16 to health education of utilizing a comprehensive
17 health curriculum in schools.

18 (f) AUTHORIZATION OF APPROPRIATIONS.—

19 (1) IN GENERAL.—There are authorized to be
20 appropriated \$50,000,000 for fiscal year 2000 and
21 such sums as may be necessary for each of the fiscal
22 years 2001 and 2002 to carry out this section.

23 (2) AVAILABILITY.—Funds appropriated pursu-
24 ant to the authority of paragraph (1) in any fiscal
25 year shall remain available for obligation and ex-

1 penditure until the end of the fiscal year succeeding
2 the fiscal year for which such funds were appro-
3 priated.

4 **SEC. 405. COMPREHENSIVE EARLY CHILDHOOD HEALTH**
5 **EDUCATION PROGRAM.**

6 (a) PURPOSE.—It is the purpose of this section to
7 establish a comprehensive early childhood health education
8 program.

9 (b) PROGRAM.—The Secretary of Health and Human
10 Services (referred to in this section as the “Secretary”)
11 shall conduct a program of awarding grants to agencies
12 conducting Head Start training to enable such agencies
13 to provide training and technical assistance to Head Start
14 teachers and other child care providers. Such program
15 shall—

16 (1) establish a training system through the
17 Head Start agencies and organizations conducting
18 Head Start training for the purpose of enhancing
19 teacher skills and providing comprehensive early
20 childhood health education curriculum;

21 (2) enable such agencies and organizations to
22 provide training to day care providers in order to
23 strengthen the skills of the early childhood workforce
24 in providing health education;

1 (3) provide technical support for health edu-
2 cation programs and curricula; and

3 (4) provide cooperation with other early child-
4 hood providers to ensure coordination of such pro-
5 grams and the transition of students into the public
6 school environment.

7 (c) USE OF FUNDS.—Grant funds under this section
8 may be used to provide training and technical assistance
9 in the areas of—

10 (1) personal health and fitness;

11 (2) prevention of chronic diseases;

12 (3) prevention and control of communicable dis-
13 eases;

14 (4) dental health;

15 (5) nutrition;

16 (6) substance use and abuse;

17 (7) accident prevention and safety;

18 (8) community and environmental health;

19 (9) mental and emotional health; and

20 (10) strengthening the role of parent involve-
21 ment.

22 (d) RESERVATION FOR INNOVATIVE PROGRAMS.—
23 The Secretary shall reserve 5 percent of the funds appro-
24 priated pursuant to the authority of subsection (e) in each

1 fiscal year for the development of innovative model health
2 education programs or curricula.

3 (e) AUTHORIZATION OF APPROPRIATIONS.—There
4 are authorized to be appropriated \$40,000,000 for fiscal
5 year 2000 and such sums as may be necessary for each
6 of the fiscal years 2001 and 2002 to carry out this section.

7 **SEC. 406. ADOLESCENT FAMILY LIFE AND ABSTINENCE.**

8 (a) DEFINITIONS.—Section 2002(a)(4)(G) of the
9 Public Health Service Act (42 U.S.C. 300z–1(a)(4)(G))
10 is amended by inserting “and abstinence” after “adop-
11 tion”.

12 (b) GEOGRAPHIC DIVERSITY.—Section 2005 of the
13 Public Health Service Act (42 U.S.C. 300z–4) is
14 amended—

15 (1) by redesignating subsections (b) and (c) as
16 subsections (c) and (d), respectively; and

17 (2) by inserting after subsection (a) the follow-
18 ing:

19 “(b) In approving applications for grants for dem-
20 onstration projects for services under this title, the Sec-
21 retary shall, to the maximum extent practicable, ensure
22 adequate representation of both urban and rural areas.”.

23 (c) SIMPLIFIED APPLICATION PROCESS.—Section
24 2006 of the Public Health Service Act (42 U.S.C. 300z–
25 5) is amended by adding at the end following:

1 “(g) The Secretary shall develop and implement a
 2 simplified and expedited application process for applicants
 3 seeking less than \$15,000 of funds available under this
 4 title for a demonstration project.”.

5 (d) AUTHORIZATION OF APPROPRIATIONS.—Section
 6 2010(a) of the Public Health Service Act (42 U.S.C.
 7 300z–9) is amended to read as follows:

8 “(a) For the purpose of carrying out this title, there
 9 are authorized to be appropriated \$75,000,000 for each
 10 of the fiscal years 2000 through 2004.”.

11 **TITLE V—PATIENT’S RIGHT TO** 12 **DECLINE MEDICAL TREATMENT**

13 **SEC. 501. PATIENT’S RIGHT TO DECLINE MEDICAL TREAT-** 14 **MENT.**

15 (a) RIGHT TO DECLINE MEDICAL TREATMENT.—

16 (1) RIGHTS OF COMPETENT ADULTS.—

17 (A) IN GENERAL.—Except as provided in
 18 subparagraph (B), a State may not restrict the
 19 right of a competent adult to consent to, or to
 20 decline, medical treatment.

21 (B) LIMITATIONS.—

22 (i) AFFECT ON THIRD PARTIES.—A
 23 State may impose limitations on the right
 24 of a competent adult to decline treatment

1 if such limitations protect third parties (in-
 2 cluding minor children) from harm.

3 (ii) TREATMENT WHICH IS NOT MEDI-
 4 CALLY INDICATED.—Nothing in this sub-
 5 section shall be construed to require that
 6 any individual be offered, or to state that
 7 any individual may demand, medical treat-
 8 ment which the health care provider does
 9 not have available, or which is, under pre-
 10 vailing medical standards, either futile or
 11 otherwise not medically indicated.

12 (2) RIGHTS OF INCAPACITATED ADULTS.—

13 (A) IN GENERAL.—Except as provided in
 14 subparagraph (B)(i) of paragraph (1), States
 15 may not restrict the right of an incapacitated
 16 adult to consent to, or to decline, medical treat-
 17 ment as exercised through the documents speci-
 18 fied in this paragraph, or through similar docu-
 19 ments or other written methods of directive
 20 which evidence the adult's treatment choices.

21 (B) ADVANCE DIRECTIVES AND POWERS
 22 OF ATTORNEY.—

23 (i) IN GENERAL.—In order to facili-
 24 tate the communication, despite incapacity,
 25 of an adult's treatment choices, the Sec-

1 retary, in consultation with the Attorney
2 General, shall develop a national advance
3 directive form that—

4 (I) shall not limit or otherwise
5 restrict, except as provided in sub-
6 paragraph (B)(i) of paragraph (1), an
7 adult's right to consent to, or to de-
8 cline, medical treatment; and

9 (II) shall, at minimum—

10 (aa) provide the means for
11 an adult to declare such adult's
12 own treatment choices in the
13 event of a terminal condition;

14 (bb) provide the means for
15 an adult to declare, at such
16 adult's option, treatment choices
17 in the event of other conditions
18 which are medically incurable,
19 and from which such adult likely
20 will not recover; and

21 (cc) provide the means by
22 which an adult may, at such
23 adult's option, declare such
24 adult's wishes with respect to all
25 forms of medical treatment, in-

cluding forms of medical treatment such as the provision of nutrition and hydration by artificial means which may be, in some circumstances, relatively nonburdensome.

(ii) NATIONAL DURABLE POWER OF ATTORNEY FORM.—The Secretary, in consultation with the Attorney General, shall develop a national durable power of attorney form for health care decisionmaking. The form shall provide a means for any adult to designate another adult or adults to exercise the same decisionmaking powers which would otherwise be exercised by the patient if the patient were competent.

(iii) HONORED BY ALL HEALTH CARE PROVIDERS.—The national advance directive and durable power of attorney forms developed by the Secretary shall be honored by all health care providers.

(iv) LIMITATIONS.—No individual shall be required to execute an advance directive. This section makes no presumption concerning the intention of an individual

1 who has not executed an advance directive.
2 An advance directive shall be sufficient,
3 but not necessary, proof of an adult's
4 treatment choices with respect to the cir-
5 cumstances addressed in the advance direc-
6 tive.

7 (C) DEFINITION.—For purposes of this
8 paragraph, the term “incapacity” means the in-
9 ability to understand or to communicate con-
10 cerning the nature and consequences of a health
11 care decision (including the intended benefits
12 and foreseeable risks of, and alternatives to,
13 proposed treatment options), and to reach an
14 informed decision concerning health care.

15 (3) HEALTH CARE PROVIDERS.—

16 (A) IN GENERAL.—No health care provider
17 may provide treatment to an adult contrary to
18 the adult's wishes as expressed personally, by
19 an advance directive as provided for in para-
20 graph (2)(B), or by a similar written advance
21 directive form or another written method of di-
22 rective which clearly and convincingly evidence
23 the adult's treatment choices. A health provider
24 who acts in good faith pursuant to the preced-
25 ing sentence shall be immune from criminal or

1 civil liability or discipline for professional mis-
 2 conduct.

3 (B) HEALTH CARE PROVIDERS UNDER
 4 THE MEDICARE AND MEDICAID PROGRAMS.—
 5 Any health care provider who knowingly pro-
 6 vides services to an adult contrary to the adult's
 7 wishes as expressed personally, by an advance
 8 directive as provided for in paragraph (2)(B),
 9 or by a similar written advance directive form
 10 or another written method of directive which
 11 clearly and convincingly evidence the adult's
 12 treatment choices, shall be denied payment for
 13 such services under titles XVIII and XIX of the
 14 Social Security Act.

15 (C) TRANSFERS.—Health care providers
 16 who object to the provision of medical care in
 17 accordance with an adult's wishes shall transfer
 18 the adult to the care of another health care pro-
 19 vider.

20 (4) DEFINITION.—For purposes of this sub-
 21 section, the term “adult” means—

22 (A) an individual who is 18 years of age or
 23 older; or

24 (B) an emancipated minor.

1 (b) FEDERAL RIGHT ENFORCEABLE IN FEDERAL
 2 COURTS.—The rights recognized in this section may be
 3 enforced by filing a civil action in an appropriate district
 4 court of the United States.

5 (c) SUICIDE AND HOMICIDE.—Nothing in this section
 6 shall be construed to permit, condone, authorize, or ap-
 7 prove suicide or mercy killing, or any affirmative act to
 8 end a human life.

9 (d) RIGHTS GRANTED BY STATES.—Nothing in this
 10 section shall impair or supersede rights granted by State
 11 law which exceed the rights recognized by this section.

12 (e) EFFECT ON OTHER LAWS.—

13 (1) IN GENERAL.—Except as specified in para-
 14 graph (2), written policies and written information
 15 adopted by health care providers pursuant to sec-
 16 tions 4206 and 4751 of the Omnibus Budget Rec-
 17 onciliation Act of 1990 (Public Law 101–508), shall
 18 be modified within 6 months after the enactment of
 19 this section to conform to the provisions of this sec-
 20 tion.

21 (2) DELAY PERIOD FOR UNIFORM FORMS.—
 22 Health care providers shall modify any written forms
 23 distributed as written information under sections
 24 4206 and 4751 of the Omnibus Budget Reconcili-
 25 ation Act of 1990 (Public Law 101–508) not later

1 than 6 months after promulgation of the forms re-
2 ferred to in clauses (i) and (ii) of subsection
3 (a)(2)(B) by the Secretary.

4 (f) INFORMATION PROVIDED TO CERTAIN INDIVID-
5 UALS.—The Secretary shall provide on a periodic basis
6 written information regarding an individual’s right to con-
7 sent to, or to decline, medical treatment as provided in
8 this section to individuals who are beneficiaries under ti-
9 tles II, XVI, XVIII, and XIX of the Social Security Act.

10 (g) RECOMMENDATIONS TO CONGRESS ON ISSUES
11 RELATING TO A PATIENT’S RIGHT OF SELF-DETERMINA-
12 TION.—Not later than 180 days after the date of the en-
13 actment of this Act, and annually thereafter for a period
14 of 3 years, the Secretary shall provide recommendations
15 to Congress concerning the medical, legal, ethical, social,
16 and educational issues related to in this section. In devel-
17 oping recommendations under this subsection the Sec-
18 retary shall address the following issues:

19 (1) The contents of the forms referred to in
20 clauses (i) and (ii) of subsection (a)(2)(B).

21 (2) Issues pertaining to the education and
22 training of health care professionals concerning pa-
23 tients’ self-determination rights.

24 (3) Issues pertaining to health care profes-
25 sionals’ duties with respect to patients’ rights, and

1 health care professionals' roles in identifying, assess-
2 ing, and presenting for patient consideration medi-
3 cally indicated treatment options.

4 (4) Issues pertaining to the education of pa-
5 tients concerning their rights to consent to, and de-
6 cline, treatment, including how individuals might
7 best be informed of such rights prior to hospitaliza-
8 tion and how uninsured individuals, and individuals
9 not under the regular care of a physician or another
10 provider, might best be informed of their rights.

11 (5) Issues relating to appropriate standards to
12 be adopted concerning decisionmaking by incapac-
13 itated adult patients whose treatment choices are not
14 known.

15 (6) Such other issues as the Secretary may
16 identify.

17 (h) EFFECTIVE DATE.—

18 (1) IN GENERAL.—This section shall take effect
19 on the date that is 6 months after the date of enact-
20 ment of this Act.

21 (2) SUBSECTION (g).—The provisions of sub-
22 section (g) shall take effect on the date of enactment
23 of this Act.

1 **TITLE VI—PRIMARY AND**
 2 **PREVENTIVE CARE PROVIDERS**

3 **SEC. 601. INCREASED MEDICARE REIMBURSEMENT FOR**
 4 **PHYSICIAN ASSISTANTS, NURSE PRACTITION-**
 5 **ERS, AND CLINICAL NURSE SPECIALISTS.**

6 (a) FEE SCHEDULE AMOUNT.—Section
 7 1833(a)(1)(O) (42 U.S.C. 1395l(a)(1)(O)) is amended by
 8 striking “85 percent” and inserting “90 percent” each
 9 place it appears.

10 (b) TECHNICAL AMENDMENTS.—Section
 11 1833(a)(1)(O) (42 U.S.C. 1395l(a)(1)(O)) is amended—
 12 (1) by striking “clinic” and inserting “clinical”;
 13 and
 14 (2) by striking the semicolon at the end and in-
 15 serting a comma.

16 (c) EFFECTIVE DATE.—The amendments made by
 17 this section shall apply with respect to services furnished
 18 and supplies provided on and after January 1, 2000.

19 **SEC. 602. REQUIRING COVERAGE OF CERTAIN NONPHYSI-**
 20 **CIAN PROVIDERS UNDER THE MEDICAID**
 21 **PROGRAM.**

22 (a) IN GENERAL.—Section 1905(a) of the Social Se-
 23 curity Act (42 U.S.C. 1396d(a)) is amended—

24 (1) in paragraph (26), by striking “and” at the
 25 end;

1 (2) by redesignating paragraph (27) as para-
2 graph (28); and

3 (3) by inserting after paragraph (26) the fol-
4 lowing:

5 “(27) services furnished by a physician assist-
6 ant, nurse practitioner, clinical nurse specialist (as
7 defined in section 1861(aa)(5)), and certified reg-
8 istered nurse anesthetist (as defined in section
9 1861(bb)(2)); and”.

10 (b) CONFORMING AMENDMENT.—Section
11 1902(a)(10)(C)(iv) of the Social Security Act (42 U.S.C.
12 1396a(a)(10)(C)(iv)) is amended by inserting “and (27)”
13 after “(24)”.

14 (c) EFFECTIVE DATE.—The amendments made by
15 this section shall apply to services furnished under title
16 XIX of the Social Security Act (42 U.S.C. 1396 et seq.)
17 beginning with the first fiscal year quarter that begins
18 after the date of enactment of this Act.

19 **SEC. 603. MEDICAL STUDENT TUTORIAL PROGRAM**
20 **GRANTS.**

21 Part C of title VII of the Public Health Service Act
22 (42 U.S.C. 293j et seq.), as amended by the Omnibus
23 Consolidated and Emergency Supplemental Appropria-
24 tions Act, 1999 (Public Law 105-277), is amended by add-
25 ing at the end thereof the following:

1 **“SEC. 749. MEDICAL STUDENT TUTORIAL PROGRAM**
 2 **GRANTS.**

3 “(a) ESTABLISHMENT.—The Secretary shall estab-
 4 lish a program to award grants to eligible schools of medi-
 5 cine or osteopathic medicine to enable such schools to pro-
 6 vide medical students for tutorial programs or as partici-
 7 pants in clinics designed to interest high school or college
 8 students in careers in general medical practice.

9 “(b) APPLICATION.—To be eligible to receive a grant
 10 under this section, a school of medicine or osteopathic
 11 medicine shall prepare and submit to the Secretary an ap-
 12 plication at such time, in such manner, and containing
 13 such information as the Secretary may require, including
 14 assurances that the school will use amounts received under
 15 the grant in accordance with subsection (c).

16 “(c) USE OF FUNDS.—

17 “(1) IN GENERAL.—Amounts received under a
 18 grant awarded under this section shall be used to—

19 “(A) fund programs under which students
 20 of the grantee are provided as tutors for high
 21 school and college students in the areas of
 22 mathematics, science, health promotion and
 23 prevention, first aide, nutrition and prenatal
 24 care;

25 “(B) fund programs under which students
 26 of the grantee are provided as participants in

1 clinics and seminars in the areas described in
2 paragraph (1); and

3 “(C) conduct summer institutes for high
4 school and college students to promote careers
5 in medicine.

6 “(2) DESIGN OF PROGRAMS.—The programs,
7 institutes, and other activities conducted by grantees
8 under paragraph (1) shall be designed to—

9 “(A) give medical students desiring to
10 practice general medicine access to the local
11 community;

12 “(B) provide information to high school
13 and college students concerning medical school
14 and the general practice of medicine; and

15 “(C) promote careers in general medicine.

16 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
17 are authorized to be appropriated to carry out this section,
18 \$5,000,000 for fiscal year 2000, and such sums as may
19 be necessary for fiscal year 2001.”.

20 **SEC. 604. GENERAL MEDICAL PRACTICE GRANTS.**

21 Part C of title VII of the Public Health Service Act
22 (as amended by section 603) is further amended by adding
23 at the end thereof the following:

1 **“SEC. 749A. GENERAL MEDICAL PRACTICE GRANTS.**

2 “(a) ESTABLISHMENT.—The Secretary shall estab-
3 lish a program to award grants to eligible public or private
4 nonprofit schools of medicine or osteopathic medicine, hos-
5 pitals, residency programs in family medicine or pedi-
6 atrics, or to a consortium of such entities, to enable such
7 entities to develop effective strategies for recruiting medi-
8 cal students interested in the practice of general medicine
9 and placing such students into general practice positions
10 upon graduation.

11 “(b) APPLICATION.—To be eligible to receive a grant
12 under this section, an entity of the type described in sub-
13 section (a) shall prepare and submit to the Secretary an
14 application at such time, in such manner, and containing
15 such information as the Secretary may require, including
16 assurances that the entity will use amounts received under
17 the grant in accordance with subsection (c).

18 “(c) USE OF FUNDS.—Amounts received under a
19 grant awarded under this section shall be used to fund
20 programs under which effective strategies are developed
21 and implemented for recruiting medical students inter-
22 ested in the practice of general medicine and placing such
23 students into general practice positions upon graduation.

24 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
25 are authorized to be appropriated to carry out this section,
26 \$25,000,000 for each of the fiscal years 2000 through

1 2002, and such sums as may be necessary for fiscal years
 2 thereafter.”.

3 **TITLE VII—COST CONTAINMENT**

4 **SEC. 701. NEW DRUG CLINICAL TRIALS PROGRAM.**

5 Part B of title IV of the Public Health Service Act
 6 (42 U.S.C. 284 et seq.) is amended by adding at the end
 7 the following:

8 **“SEC. 409C. NEW DRUG CLINICAL TRIALS PROGRAM.**

9 “(a) IN GENERAL.—The Director of the National In-
 10 stitutes of Health (referred to in this section as the ‘Direc-
 11 tor’) is authorized to establish and implement a program
 12 for the conduct of clinical trials with respect to new drugs
 13 and disease treatments determined to be promising by the
 14 Director. In determining the drugs and disease treatments
 15 that are to be the subject of such clinical trials, the Direc-
 16 tor shall give priority to those drugs and disease treat-
 17 ments targeted toward the diseases determined—

18 “(1) to be the most costly to treat;

19 “(2) to have the highest mortality; or

20 “(3) to affect the greatest number of individ-
 21 uals.

22 “(b) AUTHORIZATION OF APPROPRIATIONS.—There
 23 are authorized to be appropriated to carry out this section,
 24 \$120,000,000 for fiscal year 2000, and such sums as may

1 be necessary for each of the fiscal years 2001 through
 2 2004.”.

3 **SEC. 702. MEDICAL TREATMENT EFFECTIVENESS.**

4 (a) RESEARCH ON COST-EFFECTIVE METHODS OF
 5 HEALTH CARE.—Section 926 of the Public Health Service
 6 Act (42 U.S.C. 299c–5) is amended—

7 (1) in subsection (a)—

8 (A) by striking “1994, and” and inserting
 9 “1994,”; and

10 (B) by inserting before the period the fol-
 11 lowing: “, and such sums as may be necessary
 12 for each of the fiscal years 2000 through
 13 2002”; and

14 (2) by adding at the end the following new sub-
 15 section:

16 “(f) USE OF ADDITIONAL APPROPRIATIONS.—Within
 17 amounts appropriated under subsection (a) for each of the
 18 fiscal years 2000 through 2002 that are in excess of the
 19 amounts appropriated under such subsection for fiscal
 20 year 1999, the Secretary shall give priority to expanding
 21 research conducted to determine the most cost-effective
 22 methods of health care and for developing and disseminat-
 23 ing new practice guidelines related to such methods. In
 24 utilizing such amounts, the Secretary shall give priority
 25 to diseases and disorders that the Secretary determines

1 are the most costly to the United States and evidence a
2 wide variation in current medical practice.”.

3 (b) RESEARCH ON MEDICAL TREATMENT OUT-
4 COMES.—

5 (1) IMPOSITION OF TAX ON HEALTH INSUR-
6 ANCE POLICIES.—

7 (A) IN GENERAL.—Chapter 36 of the In-
8 ternal Revenue Code of 1986 (relating to cer-
9 tain other excise taxes) is amended by adding
10 at the end the following:

11 **“Subchapter F—Tax on Health Insurance**
12 **Policies**

“Sec. 4491. Imposition of tax.

“Sec. 4492. Liability for tax.

13 **“SEC. 4491. IMPOSITION OF TAX.**

14 “(a) GENERAL RULE.—There is hereby imposed a
15 tax equal to .001 cent on each dollar, or fractional part
16 thereof, of the premium paid on a policy of health insur-
17 ance.

18 “(b) DEFINITION.—For purposes of subsection (a),
19 the term ‘policy of health insurance’ means any policy or
20 other instrument by whatever name called whereby a con-
21 tract of insurance is made, continued, or renewed with re-
22 spect to the health of an individual or group of individuals.

1 **“SEC. 4492. LIABILITY FOR TAX.**

2 “The tax imposed by this subchapter shall be paid,
3 on the basis of a return, by any person who makes, signs,
4 issues, or sells any of the documents and instruments sub-
5 ject to the tax, or for whose use or benefit the same are
6 made, signed, issued, or sold. The United States or any
7 agency or instrumentality thereof shall not be liable for
8 the tax.”.

9 (B) CONFORMING AMENDMENT.—The
10 table of subchapters for chapter 36 of such
11 Code is amended by adding at the end the fol-
12 lowing:

 “SUBCHAPTER F. Tax on health insurance policies.”.

13 (2) ESTABLISHMENT OF TRUST FUND.—

14 (A) IN GENERAL.—Subchapter A of chap-
15 ter 98 of such Code (relating to trust fund
16 code) is amended by adding at the end the fol-
17 lowing:

18 **“SEC. 9511. TRUST FUND FOR MEDICAL TREATMENT OUT-**
19 **COMES RESEARCH.**

20 “(a) CREATION OF TRUST FUND.—There is estab-
21 lished in the Treasury of the United States a trust fund
22 to be known as the ‘Trust Fund for Medical Treatment
23 Outcomes Research’ (referred to in this section as the
24 ‘Trust Fund’), consisting of such amounts as may be ap-

1 appropriated or credited to the Trust Fund as provided in
 2 this section or section 9602(b).

3 “(b) TRANSFERS TO TRUST FUND.—There is hereby
 4 appropriated to the Trust Fund an amount equivalent to
 5 the taxes received in the Treasury under section 4491 (re-
 6 lating to tax on health insurance policies).

7 “(c) DISTRIBUTION OF AMOUNTS IN TRUST FUND.—
 8 On an annual basis the Secretary shall distribute the
 9 amounts in the Trust Fund to the Secretary of Health
 10 and Human Services. Such amounts shall be available to
 11 the Secretary of Health and Human Services to pay for
 12 research activities related to medical treatment out-
 13 comes.”.

14 (B) CONFORMING AMENDMENT.—The
 15 table of sections for subchapter A of chapter 98
 16 of such Code is amended by adding at the end
 17 the following:

“Sec. 9511. Trust Fund for Medical Treatment Outcomes Re-
 search.”.

18 (3) EFFECTIVE DATE.—The amendments made
 19 by this subsection shall apply to policies issued after
 20 December 31, 1999.

21 **SEC. 703. HEALTH CARE COST CONTAINMENT AND QUALITY**
 22 **INFORMATION PROGRAM.**

23 (a) GRANT PROGRAM.—

1 (1) IN GENERAL.—The Secretary of Health and
2 Human Services (referred to in this section as the
3 “Secretary”) shall make grants to States that estab-
4 lish or operate health care cost containment and
5 quality information systems (as defined in subsection
6 (f)(1)). In order to be eligible for a grant under this
7 section, a State must establish or operate a system
8 which, at a minimum, meets the Federal standards
9 established under subsection (c).

10 (2) USE OF FUNDS.—States may use grant
11 funds received under this section only to establish a
12 health care cost containment and quality information
13 system or to improve an existing system operated by
14 the State.

15 (b) SUBMISSION OF APPLICATIONS.—To be eligible
16 for a grant under this section, a State must submit an
17 application to the Secretary within 2 years after the date
18 of the enactment of this section. Such application shall
19 be submitted in a manner determined appropriate by the
20 Secretary and shall include the designation of a State
21 agency that will operate the health care cost containment
22 and quality information system for the State. The Sec-
23 retary shall approve or disapprove a State application
24 within 6 months after its submission.

1 (c) MINIMUM FEDERAL STANDARDS.—Not later than
2 6 months after the date of the enactment of this section,
3 the Secretary, after consultation with the Agency for
4 Health Care Policy and Research, other Federal agencies,
5 the Joint Commission on Accreditation of Hospitals,
6 States, health care providers, consumers, insurers, health
7 maintenance organizations, businesses, academic health
8 centers, and labor organizations that purchase health care,
9 shall establish Federal standards for the operation of
10 health care cost containment and quality information sys-
11 tems by States receiving grants under this section.

12 (d) COLLECTION AND PUBLIC DISSEMINATION OF
13 INFORMATION BY STATES.—

14 (1) IN GENERAL.—A State receiving a grant
15 under this section shall require that a health care
16 cost containment and quality information system will
17 collect at least the information described in para-
18 graph (2) and publicly disseminate such information
19 in a useful format to appropriate persons such as
20 businesses, consumers of health care services, labor
21 organizations, health plans, hospitals, and other
22 States.

23 (2) INFORMATION DESCRIBED.—The informa-
24 tion described in this paragraph is the following:

25 (A) Information on hospital charges.

1 (B) Clinical data.

2 (C) Demographic data.

3 (D) Information regarding treatment of in-
4 dividuals by particular health care providers.

5 (3) PRIVACY AND CONFIDENTIALITY.—The
6 State cost containment and quality information sys-
7 tem shall ensure that patient privacy and confiden-
8 tiality is protected at all times.

9 (e) COMPLIANCE.—If the Secretary determines that
10 a State receiving grant funds under this section has failed
11 to operate a system in accordance with the terms of its
12 approved application, the Secretary may withhold payment
13 of such funds until the State remedies such noncompli-
14 ance.

15 (f) DEFINITIONS.—For purposes of this section—

16 (1) the term “health care cost containment and
17 quality information system” means a system which
18 is established or operated by a State in order to col-
19 lect and disseminate the information described in
20 subsection (d)(2) in accordance with subsection
21 (d)(1) for the purpose of providing information on
22 health care costs and outcomes in the State; and

23 (2) the term “State” means a State, the Dis-
24 trict of Columbia, the Commonwealth of Puerto
25 Rico, the Virgin Islands, Guam, American Samoa,

1 and includes the Commonwealth of the Northern
2 Mariana Islands.

3 (g) AUTHORIZATION.—

4 (1) IN GENERAL.—There are authorized to be
5 appropriated for the purpose of carrying out this
6 section not more than \$150,000,000 for fiscal years
7 2000 through 2002, and such sums as may be nec-
8 essary thereafter, to remain available until expended.

9 (2) ALLOCATION TO STATES.—The Secretary
10 shall allocate the amounts available for grants under
11 this section in any fiscal year in accordance with a
12 formula developed by the Secretary which takes into
13 account—

14 (A) the number of hospitals in a State rel-
15 ative to the total number of hospitals in all
16 States;

17 (B) the population of the State relative to
18 the total population of all States; and

19 (C) the type of system operated or in-
20 tended to be operated by the State, including
21 whether the State establishes an independent
22 State agency to operate the system.

1 **TITLE VIII—TAX INCENTIVES**
 2 **FOR PURCHASE OF QUALI-**
 3 **FIED LONG-TERM CARE IN-**
 4 **SURANCE**

5 **SEC. 801. CREDIT FOR QUALIFIED LONG-TERM CARE PRE-**
 6 **MIUMS.**

7 (a) GENERAL RULE.—Subpart C of part IV of sub-
 8 chapter A of chapter 1 of the Internal Revenue Code of
 9 1986 (relating to refundable credits) is amended by redes-
 10 ignating section 35 as section 36 and by inserting after
 11 section 34 the following:

12 **“SEC. 35. LONG-TERM CARE INSURANCE CREDIT.**

13 “(a) GENERAL RULE.—In the case of an individual,
 14 there shall be allowed as a credit against the tax imposed
 15 by this subtitle for the taxable year an amount equal to
 16 the applicable percentage of the premiums for a qualified
 17 long-term care insurance contract (as defined in section
 18 7702B(b)) paid during such taxable year for such individ-
 19 ual or the spouse of such individual.

20 “(b) APPLICABLE PERCENTAGE.—

21 “(1) IN GENERAL.—For purposes of this sec-
 22 tion, the term ‘applicable percentage’ means 28 per-
 23 cent reduced (but not below zero) by 1 percentage
 24 point for each \$1,000 (or fraction thereof) by which

1 the taxpayer's adjusted gross income for the taxable
 2 year exceeds the base amount.

3 “(2) BASE AMOUNT.—For purposes of para-
 4 graph (1) the term ‘base amount’ means—

5 “(A) except as otherwise provided in this
 6 paragraph, \$25,000,

7 “(B) \$40,000 in the case of a joint return,
 8 and

9 “(C) zero in the case of a taxpayer who—
 10 “(i) is married at the close of the tax-
 11 able year (within the meaning of section
 12 7703) but does not file a joint return for
 13 such taxable year, and

14 “(ii) does not live apart from the tax-
 15 payer's spouse at all times during the tax-
 16 able year.

17 “(c) COORDINATION WITH MEDICAL EXPENSE DE-
 18 Duction.—Any amount allowed as a credit under this
 19 section shall not be taken into account under section
 20 213.”.

21 (b) CONFORMING AMENDMENT.—The table of sec-
 22 tions for such subpart C is amended by striking the item
 23 relating to section 35 and inserting the following:

“Sec. 35. Long-term care insurance credit.
 “Sec. 36. Overpayments of tax.”.

1 (c) EFFECTIVE DATE.—The amendments made by
 2 this section shall apply to taxable years beginning after
 3 December 31, 1999.

4 **SEC. 802. INCLUSION OF QUALIFIED LONG-TERM CARE IN-**
 5 **SURANCE IN CAFETERIA PLANS AND FLEXI-**
 6 **BLE SPENDING ARRANGEMENTS.**

7 (a) CAFETERIA PLANS.—The last sentence of section
 8 125(f) of the Internal Revenue Code of 1986 (defining
 9 qualified benefits) is amended by striking “shall not” and
 10 inserting “shall”.

11 (b) FLEXIBLE SPENDING ARRANGEMENTS.—Section
 12 106(c) of the Internal Revenue Code of 1986 (relating to
 13 contributions by employer to accident and health plans)
 14 is amended—

15 (1) in paragraph (1), by striking “include” and
 16 inserting “shall not”; and

17 (2) in the heading, by striking “INCLUSION”
 18 and inserting “EXCLUSION”.

19 (c) EFFECTIVE DATE.—The amendments made by
 20 this section shall apply to taxable years beginning after
 21 December 31, 1998.

1 **SEC. 803. EXCLUSION FROM GROSS INCOME FOR AMOUNTS**
 2 **RECEIVED ON CANCELLATION OF LIFE IN-**
 3 **SURANCE POLICIES AND USED FOR QUALI-**
 4 **FIED LONG-TERM CARE INSURANCE CON-**
 5 **TRACTS.**

6 (a) IN GENERAL.—

7 (1) EXCLUSION FROM GROSS INCOME.—

8 (A) IN GENERAL.—Part III of subchapter
 9 B of chapter 1 of the Internal Revenue Code of
 10 1986 (relating to items specifically excluded
 11 from gross income) is amended by redesignat-
 12 ing section 139 as section 140 and by inserting
 13 after section 138 the following new section:

14 **“SEC. 139. AMOUNTS RECEIVED ON CANCELLATION, ETC.**
 15 **OF LIFE INSURANCE CONTRACTS AND USED**
 16 **TO PAY PREMIUMS FOR QUALIFIED LONG-**
 17 **TERM CARE INSURANCE.**

18 “No amount (which but for this section would be in-
 19 cludible in the gross income of an individual) shall be in-
 20 cluded in gross income on the whole or partial surrender,
 21 cancellation, or exchange of any life insurance contract
 22 during the taxable year if—

23 “(1) such individual has attained age 59½ on
 24 or before the date of the transaction, and

25 “(2) the amount otherwise includible in gross
 26 income is used during such year to pay for any

1 qualified long-term care insurance contract (as de-
 2 fined in section 7702B(b)) which—

3 “(A) is for the benefit of such individual or
 4 the spouse of such individual if such spouse has
 5 attained age 59½ on or before the date of the
 6 transaction, and

7 “(B) may not be surrendered for cash.”.

8 (B) CONFORMING AMENDMENT.—The
 9 table of sections for such part III is amended
 10 by striking the item relating to section 139 and
 11 inserting the following:

“Sec. 139. Amounts received on cancellation, etc. of life insurance
 contracts and used to pay premiums for qualified
 long-term care insurance.

“Sec. 140. Cross references to other Acts.”.

12 (2) CERTAIN EXCHANGES NOT TAXABLE.—Sec-
 13 tion 1035(a) of such Code (relating to certain ex-
 14 changes of insurance contracts) is amended by strik-
 15 ing the period at the end of paragraph (3) and in-
 16 serting “; or”, and by adding at the end the follow-
 17 ing:

18 “(4) in the case of an individual who has at-
 19 tained age 59½, a contract of life insurance or an
 20 endowment or annuity contract for a qualified long-
 21 term care insurance contract (as defined in section
 22 7702B(b)), if the qualified long-term care insurance
 23 contract may not be surrendered for cash.”.

1 (b) EFFECTIVE DATE.—The amendments made by
 2 this section shall apply to taxable years beginning after
 3 December 31, 1999.

4 **SEC. 804. USE OF GAIN FROM SALE OF PRINCIPAL RESI-**
 5 **DENCE FOR PURCHASE OF QUALIFIED LONG-**
 6 **TERM HEALTH CARE INSURANCE.**

7 (a) IN GENERAL.—Subsection (d) of section 121 of
 8 the Internal Revenue Code of 1986 (relating to exclusion
 9 of gain from sale of principal) is amended by adding at
 10 the end the following:

11 “(9) ELIGIBILITY OF HOME EQUITY CONVER-
 12 SION SALE-LEASEBACK TRANSACTION FOR EXCLU-
 13 SION.—

14 “(A) IN GENERAL.—For purposes of this
 15 section, the term ‘sale or exchange’ includes a
 16 home equity conversion sale-leaseback trans-
 17 action.

18 “(B) HOME EQUITY CONVERSION SALE-
 19 LEASEBACK TRANSACTION.—For purposes of
 20 subparagraph (A), the term ‘home equity con-
 21 version sale-leaseback’ means a transaction in
 22 which—

23 “(i) the seller-lessee—

24 “(I) sells property which during
 25 the 5-year period ending on the date

1 of the transaction has been owned and
2 used as a principal residence by such
3 seller-lessee for periods aggregating 2
4 years or more,

5 “(II) uses a portion of the pro-
6 ceeds from such sale to purchase a
7 qualified long-term care insurance
8 contract (as defined in section
9 7702B(b)), which contract may not be
10 surrendered for cash,

11 “(III) obtains occupancy rights
12 in such property pursuant to a written
13 lease requiring a fair rental, and

14 “(IV) receives no option to repur-
15 chase the property at a price less than
16 the fair market price of the property
17 unencumbered by any leaseback at the
18 time such option is exercised, and

19 “(ii) the purchaser-lessor—

20 “(I) is a person,

21 “(II) is contractually responsible
22 for the risks and burdens of owner-
23 ship and receives the benefits of own-
24 ership (other than the seller-lessee’s

1 occupancy rights) after the date of
2 such transaction, and

3 “(III) pays a purchase price for
4 the property that is not less than the
5 fair market price of such property en-
6 cumbered by a leaseback, and taking
7 into account the terms of the lease.

8 “(C) ADDITIONAL DEFINITIONS.—For pur-
9 poses of subparagraph (B)—

10 “(i) OCCUPANCY RIGHTS.—The term
11 ‘occupancy rights’ means the right to oc-
12 cupy the property for any period of time,
13 including a period of time measured by the
14 life of the seller-lessee on the date of the
15 sale-leaseback transaction (or the life of
16 the surviving seller-lessee, in the case of
17 jointly held occupancy rights), or a periodic
18 term subject to a continuing right of re-
19 newal by the seller-lessee (or by the surviv-
20 ing seller-lessee, in the case of jointly held
21 occupancy rights).

22 “(ii) FAIR RENTAL.—The term ‘fair
23 rental’ means a rental for any subsequent
24 year which equals or exceeds the rental for

1 the 1st year of a sale-leaseback trans-
2 action.”.

3 (b) EFFECTIVE DATE.—The amendment made by
4 this section shall apply to sales after December 31, 1999,
5 in taxable years beginning after such date.

6 **TITLE IX—NATIONAL FUND FOR** 7 **HEALTH RESEARCH**

8 **SEC. 901. ESTABLISHMENT OF FUND.**

9 (a) ESTABLISHMENT.—There is established in the
10 Treasury of the United States a fund, to be known as the
11 “National Fund for Health Research” (in this section re-
12 ferred to as the “Fund”), consisting of such amounts as
13 are transferred to the Fund under subsection (b) and any
14 interest earned on investment of amounts in the Fund.

15 (b) TRANSFERS TO FUND.—

16 (1) IN GENERAL.—The Secretary of the Treas-
17 ury shall transfer to the Fund amounts equivalent to
18 amounts designated under paragraph (2) and re-
19 ceived in the Treasury.

20 (2) AMOUNTS.—

21 (A) HEALTH PLAN SET ASIDE.—With re-
22 spect to each calendar year beginning with the
23 first full calendar year after the date of enact-
24 ment of this Act, each health plan shall set

1 aside and transfer to the Treasury of the
2 United States an amount equal to—

3 (i) for the first full calendar year,
4 0.25 percent of all health premiums re-
5 ceived with respect to the plan for such
6 year;

7 (ii) for the second full calendar year,
8 0.5 percent of all health premiums received
9 with respect to the plan for such year;

10 (iii) for the third full calendar year,
11 0.75 percent of all health premiums re-
12 ceived with respect to the plan for such
13 year; and

14 (iv) for the fourth and each succeed-
15 ing full calendar year, 1 percent of all
16 health premiums received with respect to
17 the plan for such year.

18 (3) TRANSFERS BASED ON ESTIMATES.—The
19 amounts transferred by paragraph (1) shall annually
20 be transferred to the Fund within 30 days after the
21 President signs an appropriations Act for the De-
22 partments of Labor, Health and Human Services,
23 and Education, and related agencies, or by the end
24 of the first quarter of the fiscal year. Proper adjust-
25 ment shall be made in amounts subsequently trans-

ferred to the extent prior estimates were in excess of or less than the amounts required to be transferred.

(4) DEFINITION.—As used in this subsection, the term “health plan” means a group health plan (as defined in section 2791(a) of the Public Health Service Act and any individual health insurance (as defined in section 2791(b)(5) of such Act) operated by a health insurance issuer.

(c) OBLIGATIONS FROM FUND.—

(1) IN GENERAL.—Subject to the provisions of paragraph (4), with respect to the amounts made available in the Fund in a fiscal year, the Secretary of Health and Human Services shall distribute—

(A) 2 percent of such amounts during any fiscal year to the Office of the Director of the National Institutes of Health to be allocated at the Director’s discretion for the following activities:

(i) for carrying out the responsibilities of the Office of the Director, including the Office of Research on Women’s Health and the Office of Research on Minority Health, the Office of Alternative Medicine, the Office of Rare Disease Research, the Office

1 of Behavioral and Social Sciences Research
2 (for use for efforts to reduce tobacco use),
3 the Office of Dietary Supplements, and the
4 Office for Disease Prevention; and

5 (ii) for construction and acquisition of
6 equipment for or facilities of or used by
7 the National Institutes of Health;

8 (B) 2 percent of such amounts for transfer
9 to the National Center for Research Resources
10 to carry out section 1502 of the National Insti-
11 tutes of Health Revitalization Act of 1993 con-
12 cerning Biomedical and Behavioral Research
13 Facilities;

14 (C) 1 percent of such amounts during any
15 fiscal year for carrying out section 301 and
16 part D of title IV of the Public Health Service
17 Act with respect to health information commu-
18 nications; and

19 (D) the remainder of such amounts during
20 any fiscal year to member institutes and cen-
21 ters, including the Office of AIDS Research, of
22 the National Institutes of Health in the same
23 proportion to the total amount received under
24 this section, as the amount of annual appro-
25 priations under appropriations Acts for each

1 member institute and Centers for the fiscal year
2 bears to the total amount of appropriations
3 under appropriations Acts for all member insti-
4 tutes and Centers of the National Institutes of
5 Health for the fiscal year.

6 (2) PLANS OF ALLOCATION.—The amounts
7 transferred under paragraph (1)(D) shall be allo-
8 cated by the Director of the National Institutes of
9 Health or the various directors of the institutes and
10 centers, as the case may be, pursuant to allocation
11 plans developed by the various advisory councils to
12 such directors, after consultation with such direc-
13 tors.

14 (3) GRANTS AND CONTRACTS FULLY FUNDED
15 IN FIRST YEAR.—With respect to any grant or con-
16 tract funded by amounts distributed under para-
17 graph (1), the full amount of the total obligation of
18 such grant or contract shall be funded in the first
19 year of such grant or contract, and shall remain
20 available until expended.

21 (4) TRIGGER AND RELEASE OF MONIES AND
22 PHASE-IN.—

23 (A) TRIGGER AND RELEASE.—No expendi-
24 ture shall be made under paragraph (1) during
25 any fiscal year in which the annual amount ap-

1 appropriated for the National Institutes of Health
2 is less than the amount so appropriated for the
3 prior fiscal year.

4 (B) PHASE-IN.—The Secretary of Health
5 and Human Services shall phase-in the distribu-
6 tions required under paragraph (1) so that—

7 (i) 25 percent of the amount in the
8 Fund is distributed in the first fiscal year
9 for which funds are available;

10 (ii) 50 percent of the amount in the
11 Fund is distributed in the second fiscal
12 year for which funds are available;

13 (iii) 75 percent of the amount in the
14 Fund is distributed in the third fiscal year
15 for which funds are available; and

16 (iv) 100 percent of the amount in the
17 Fund is distributed in the fourth and each
18 succeeding fiscal year for which funds are
19 available.

20 (d) BUDGET TREATMENT OF AMOUNTS IN FUND.—
21 The amounts in the Fund shall be excluded from, and
22 shall not be taken into account, for purposes of any budget
23 enforcement procedure under the Congressional Budget

- 1 Act of 1974 or the Balanced Budget and Emergency Defi-
- 2 cit Control Act of 1985.

